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Address.

PUBLIC HEALTH.

Address of Hon. Benjamin Loring Young, Speaker of the House of Representatives, at Springfield, before the members of Medical Societies of Berkshire, Hampshire, Hampden and Franklin Counties—October 7, 1921.

It is a difficult task for a layman to preach a sermon on public health. It is doubly hard when the congregation is composed of doctors who on this topic know far more than the preacher. Dr. Merrill's prospectus of this meeting states that I am to tell you how we politicians feel the pulse of our constituents, and how we frame legislation not merely to serve the public but also to secure our reëlection. Although that is almost like giving away state secrets, I will do my best to obey orders. But first I want a few minutes for my sermon and will, according to rules, begin with a text,—the oft-quoted remark of Benjamin Disraeli, Lord Beaconsfield. He said:

> "The public health is the foundation on which reposes the happiness of the people and the power of a country. The care of the public health is the first duty of a statesman."

The necessity for active and intelligent public health work is obvious. Productive capacity in almost all lines of human activity, whether of brain or hand, in the factory or on the farm, is founded upon health, the absence of disease, whether physical, mental or moral. The sound mind in the sound body is the basis for national as well as individual progress and success.

In addition to the loss in efficiency which follows from the absence of health, often intangible and difficult to measure, the state faces a staggering cost in actual dollars and cents due to the same cause. I will give you some illuminating figures. The total appropriations for the state government of Massachusetts for 1921 are $39,736,266, just short of $40,000,000. This bill is met through various forms of taxation, but is paid by the normal self-supporting members of society. How many people realize that of this large expenditure,—more than $16,000,000—40 cents on every dollar goes for the support of poor unfortunates who cannot maintain themselves as normal units in a self-supporting community. This cannot all be attributed to physical disease alone or to physical and mental disease combined, but these factors play a large part. Everyone realizes today the widespread evil effects of mental disease, defect and degeneracy as contributing causes to many other social evils—crime, prostitution, pauperism, alcoholism—to name but a few of the more important. The direct state expenditures for the care and support of these non-productive classes take 40 cents on every dollar of your state tax bill and mine. Here are the figures:

Dept. of Mental Diseases with 17 hospitals and other institutions caring for more than 18,000 insane, epileptic and feeble-minded patients	$7,861,485
Dept. of Public Health for preventive health work and the support of four state tuberculosis sanatoria	1,142,990
Dept. of Correction for the five state penal institutions	1,385,440
Division of the Blind and for education and care of the deaf and blind	523,000
Dept. of Public Welfare for poor relief, the support of 8000 state wards, juvenile training schools, etc.	4,836,000
Interest and Debt Requirements on past loans, still outstanding, incurred for the above purposes, payable during 1921, not less than	700,000
TOTAL	$16,446,915

You will note that these figures do not include the expenses of the county and municipal tuberculosis hospitals, the 21 county jails and houses of correction, the county training schools nor the expense of cities, towns and private charitable corporations for similar branches of work. The state figures alone, however, are formidable enough.

Taxation is already far heavier in Massachusetts than in many other states. We know that the tax burden on our productive industries and on our farms and homes has reached a point of real danger. Preventive health work today, although it does cost money, seems to me to be one sure way of reducing this burden for future generations. If the burden is not lessened, if it is allowed to increase, disaster will surely come, because even in a hive of industry the ability of the workers to support the unfortunate drones has a limit. These figures prove, indeed, the truth of Disraeli's statement. To help remedy the distressing social and economic conditions which these state expenditures prove now to exist, to give future generations every possible advantage both in hereditary and environment, to promote maternal and infant welfare, to combat weakness and disease in every form—here are but a few of the manifold tasks which the dictum of Disraeli imposes upon the state.

The state is doing its best to perform this duty. You are, of course, familiar with the organization and work of the Department of Public Health. I will not, therefore, discuss that particular phase of the subject in any detail. I do wish to point out, however, some of the important steps taken during the past few years through legislative action, all of which I can recall during my own brief service to the General Court.

1. The law of 1916, which provided for the construction of tuberculosis hospitals by the several counties so that adequate hospital accommodations might be permanently available for all persons suffering from tuberculosis.

2. The creation in 1918, under the stimulus of the war, of the subdivision on venereal diseases by the Department of Public Health, with supervision today of over 16 clinics throughout the state and a campaign depending for its success upon the individual physicians.

3. The law of 1920, authorizing cities and towns to establish dental, medical and health clinics and to conduct campaigns of general education on public health matters.

Two other laws of 1919 and 1921 are really epoch making in their importance.

4. Chapter 277 of 1919 provides that "The school committee of each city and town shall . . . annually . . . ascertain, under regulations prescribed by the Board of Education and the Director of the Commission on Mental Diseases, the number of children three years or more retarded in mental development, who are in attendance upon the public schools of its city or town, or who are of school age and reside therein." Here is a true preventive Act. Under its operation, we will sift out in early youth many cases of mental defect which otherwise might drift helplessly along for many years, a constant burden to themselves and the community. Some may be capable of special training, others will need permanent custodial treatment. This Act will give us an inventory of our defective elements, the necessary foundation for all future plans and work.

5. Of equal importance is Chapter 415 of 1921 which provides that every person indicted for a capital offence and every person previously indicted more than once, or previously convicted for felony, who is again indicted or bound over for trial, shall be examined by the Department of Mental Diseases for a determination of his mental condition and the existence of any mental disease or defect which would affect his criminal responsibility. The report of the Department is to be filed in Court and will be accessible to the Court, the District Attorney, the Counsel for the accused, and shall be admissible as legal evidence.

The eventual effect of this law will be to abolish the often absurd and sometimes scandalous battle of wits between physicians and lawyers on both sides of the case over the question of mental disease and legal responsibility, and to substitute for the expert evidence which often belied its name, a non-partisan, scientific report. When we consider that the investigations of Dr. Guy G. Fernald and Dr. A. Warren Stearns have shown that at least 20 per cent. of the inmates of our penal institutions suffer from marked mental defects, we can see clearly that this law will eventually

take out of our prison population that large group of defective delinquents who need curative or custodial treatment rather than punishment, and who should be properly taken care of, not in prisons but in institutions of some other sort.

6. Preventive legislation aimed at remedying physical rather than mental defects, was adopted by the legislature of 1921 in the laws making compulsory the appointment of school nurses in the public schools and providing that physical training and exercise be made a part of the regular curriculum of the public schools of the state.

The successful operation of all these laws depends upon the support they receive in the various cities and towns. The passage of a law has no permanent effect unless it is supported by local public opinion. For this wide program of health work, I confidently ask for the continued support of the physicians of the state.

Every step in this program has been taken at the suggestion and with the support of the medical profession. I do not believe that one of these laws is subject to the criticism so often heard today of "state medicine." Exactly what that term means, I do not know. I have never seen an accurate definition. I presume, however, that it means a complete substitution of government action, through salaried officials, in place of the present methods of the treatment of disease by private practitioners. I do not believe that any public official in Massachusetts desires to have the state embark upon any new work or add to its expenditures unless such action is imperative for the public good. It seems perfectly clear that where whole communities are left without private medical service, a situation now actually existing in parts of Massachusetts, a condition has arisen which may require public action, through the state or local government, by the creation of community hospitals, or otherwise. New legislation may — undoubtedly will be passed by the General Court to meet actual needs as they arrive. Although I am obviously unfitted to discuss the difficult question of state medicine, I wish to make one point very clear. I have never heard any serious proposal for laws which would destroy the independence of the medical profession or hazard the professional standards of medicine by placing the burden of their maintenance in political hands rather than in the hands of the physicians and medical societies themselves.

The General Court is composed of men of various occupations. We are fortunate in occasionally having among our members a few physicians. In the main, however, we must rely upon evidence and argument presented at committee hearings. Last year, the General Court considered more than 2500 separate matters, of which at least 100 had some relation to public health. The Committee on Public Health itself heard more than 60 separate proposals for legislation. Each year we must decide upon the various recommendations made by the Governor, the Department of Public Health and other state departments, bills introduced by members of the House and Senate and petitions filed by private organizations and individuals. I know I speak for my colleagues in making an urgent appeal for the utmost possible amount of coöperation and advice in all our work. The doctors of Massachusetts could easily create and lead all public opinion on health matters. You have the knowledge, the ability and the organization. If legislation is passed which endangers health standards or lessens the prestige of the medical profession, it is usually because the doctors have let the case go by default. By intelligent interest on your part, you can not only insure the success of the health legislation now on our books, but you can point the way to all future work to be done by the state for the protection and improvement of the public health.

Original Articles.

THE SURGICAL ABDOMEN IN CHILDREN; ITS DIAGNOSIS AND PROGNOSIS.

By Thomas H. Lanman, M.D., Boston.

It has been of considerable interest to observe how much more common than is generally supposed, are the abdominal conditions in infancy and childhood that require surgical intervention. A study of the figures of the last five years of the Surgical Service of the Children's Hospital is of especial interest as regards the mortality rates for the various conditions under consideration.

HERNIA.

While hernia is the largest class of cases admitted to the wards, it needs but little comment, and is, of course, comparatively easy of diagnosis. There have been 1064 operations for hernia out of 4748 admissions to the hospital in the period of five years. Of these 1064 operations, 7%, or 74, have been for umbilical hernia. The rest were for inguinal hernia, and this includes the various types of inguinal hernia, such as indirect (the commonest), direct, congenital, scrotal, and those accompanying hydrocele and undescended testicles.

The diagnosis is rarely in doubt. In umbilical hernia, it is self-evident. In inguinal, if the mass itself is visible, the history of the parent and a certain definite thickening of the cord structures as they pass over the pubis

on the affected side and a more patent external ring, will give the diagnosis. Hydrocele may be determined by its translucency and the inability to reduce the mass even when the child does not cry. Strangulation and incarceration of inguinal hernia is very rare. Out of nearly 500 cases in the last two years, only three were strangulated; and of these three, two were reduced on the operating table when the child was under ether. The story of the mass in the groin that stays the same size, is translucent, and does not reduce when the child is lying down and quiet (especially in the absence of any symptoms of strangulation) means, practically always, hydrocele.

The prognosis is good, and the hernia should, of course, be operated on. Of 1044 operations there have been only one death in cases of inguinal hernia, and two in umbilical. All three were undernourished infants.

The age at time of operation matters little, though it is the practice at the Children's Hospital to hold the hernia with a yarn truss at least until the baby is weaned, or until it has been through its first summer. If it cannot be held, or home conditions are bad, operation is indicated. The age of choice for operation on undescended testicle is at least four to six years.

Hydrocele is treated by radical operation; in infancy uncomplicated hydrocele is left unoperated until the child is weaned, or, if it grows so fast as to cause pressure on the testis, tapping may be resorted to as often as is necessary until the desired age is reached. Encysted hydrocele of the cord is occasionally encountered and in rare cases may become infected. In these cases, it should be remembered that there is nearly always a small, almost obliterated, congenital hernia, which should be treated at the time of operation. In those cases that are infected, great care should be taken not to allow the infection to break through to the peritoneal cavity. Hydrocele of the canal of Nuck in girls is rare, but should be borne in mind in making a differential diagnosis.

Umbilical hernia can, in the vast majority of cases, be cured by strapping. There have been 362 cases in the Out-patient Clinic, and only 74, or 20%, required operation. This figure would be lower among the more intelligent classes where better supervision of treatment could be carried out. The chief difficulty we encounter is the failure on the part of parents to realize that the strapping must be continuous, and that great care must be taken when changing the strapping not to allow the child to cry.

There have been three cases of epigastric hernia and two of femoral hernia.

Recurrence in inguinal hernia is practically nil. I have found only three cases. In all, the first operation was at very early age,—12 to 13 months,—and the children developed some bronchitis following operation. It should not occur at all, of course, and although I found only three cases, there are doubtless others; but in the Out-patient class of cases it is very difficult to get accurate follow-up reports.

SURGERY OF THE ABDOMEN IN THE NEW-BORN.

This subject may be covered rather briefly.

A. *Umbilical Sepsis.* This is seen in the hospital only in very desperate cases, but undoubtedly is more common in general practice. The cases we see are of three types.

The most favorable is that which presents a phlegmon of the abdominal wall which, by poulticing and by incision, if the abscess points, may lead to recovery. The prognosis is grave because the infants that develop this infection are of low vitality and resistance.

Then there is the type that has thrombosis of the hypogastric vessels and which will show septic emboli in the extremities, scrotum, liver or spleen. The mortality here is 100%.

The last type is the one that develops a peritonitis probably by direct extension. Of four such cases operated on and drained, none recovered. I think operation is indicated if there is evidence of peritonitis, but it is a last resort and probably hopeless.

B. *Malformations of the Gastrointestinal Tract.* These are generally either an atresia in greater or less degree of some part of the bowel; a complete absence of some part; or, more commonly, imperforate anus. The diagnosis is not long in doubt. No passage of meconium or feces by rectum, progressive distention and vomiting, going on to collapse.

Except for those cases that have merely an unbroken anal membrane, that can be broken by finger or hemostat, or those cases where the obstruction is so low that the normal gut may be brought down and sutured to the skin at the anus, the prognosis is very bad. Of twelve such cases operated, none have lived. The operation for anastomosis is generally severe enough to kill the patient, and relief by enterostomy is seldom ultimately successful. In infants and children it is practically impossible to keep a permanent enterostomy or colostomy, because the constant crying will cause a prolapse that is extremely difficult to deal with.

Of 27 cases of imperforate anus treated without colostomy, 22 have recovered; a mortality of 18%. It is very important in the after-care of these cases that they report for dilatation for a period of several months.

PYLORIC STENOSIS.

This is not an uncommon condition. The hospital figures give a series of 66 operations for this condition, with six deaths; a mortality of 9.9%. It is, however, becoming recognized sooner and with the development of the

technique of the Ramsted operation the condition has lost much of its gravity of prognosis. During the last year there were 22 operations for pyloric stenosis with no deaths.

The history and picture of pyloric stenosis is striking. The infant who has been doing well, begins to vomit; first occasionally, then regularly with each feeding. The vomiting is forcible and projectile. There is also constipation and rapid and progressive wasting.

In making a diagnosis there are several points to consider. The time of onset is rarely before the first week; usually in the first month or six weeks, rarely later. The vomiting is constant. It comes directly after, or even during, feeding, and is more forcible than in any other condition. The story that the baby vomits over the foot of the crib, or three to five feet from the mother's lap, is common. Generally all the food is vomited; small amounts of regurgitation are not common. The vomitus is the food just taken, though in some cases the baby will keep two or three feedings and then vomit the whole amount. There is progressive and alarming wasting; generally constipation, but no fever.

Directly after taking food or water, characteristic waves of peristalsis may be seen in the upper abdomen. They start from the left lower rib margin and move across to the right. They may often be excited by gently stroking the skin of the abdomen. This sign is very characteristic of the disease, and there is generally no evidence of pain. By careful examination, the tumor, which is the result of the thickened and hardened pylorus, may be felt. In most cases in the extreme relaxation which follows a vomiting attack, a small olive shaped tumor may be felt about two inches below the ribs in the right mammary line. In cases of doubt, an examination under ether is justified. An x-ray study after barium solution is also of great assistance. In true stenosis practically no barium solution will pass through the pylorus even after six to eight hours. In pyloric spasm there will be always some considerable part of the solution shown in the small bowel.

The character of the vomiting, the age, the rapid wasting, palpation of tumor, and visible peristalsis justify exploration. The operation has become a simple one, and the results most gratifying. The six deaths on the service were all in cases in which the condition was not recognized until the infant was in an extremely critical condition.

The question of these patients later developing ulcer at the pylorus must needs be left to the future.

INTUSSUSCEPTION.

This is the commonest cause of acute obstruction in children. Of 92 cases of acute obstruction in this report, 70 were due to intussusception. The commonest age is four to twelve months, and nearly all that we see have been in the first two years; and one half are between the ages of four and nine months. The cause is still extremely obscure. The best article on this subject is "The Diagnosis and Treatment of Intussusception," by Charles P. B. Clubbe of Sydney, New South Wales.[1]

The onset and symptoms, especially in the majority of cases seen, are acute and very marked. The onset is sudden, the pain paroxysmal and very severe. The child will cry out as with nothing else that is met with in children. We so often get the voluntary statement from the mother that in this attack, the pain was different from anything else the child ever complained of. Also there is likely to be a very definite time set for the onset. For instance, the mother will state that at supper the child was well, but that at 8.15 he suddenly cried out with pain and vomited.

The vomiting is persistent and often projectile. It is at first a reflex vomiting from peritoneal shock, then obstructive, and is never absent in the acute cases, though as the disease goes on it may become less in amount. It may also become fecal, which shows complete obstruction rather than strangulation. There may be one or two loose stools after the onset, but after the lower bowel is emptied, no feces or gas come through. There is mucus, then mucus and blood, then only blood.

The prostration is great, going on to collapse; the face is anxious; extremities cold; pallor and sweating marked. Temperature at first is subnormal. Then, as the general condition gets worse the temperature may rise to 105-106 with symptoms of peritonitis.

The palpation of a tumor is a very constant finding and very important in diagnosis. This will be found early in most cases; and as most cases start at the ileocecal valve, it is first felt in the right lower quadrant or right upper quadrant. Soon it crosses over and is generally felt in the left flank as a "sausage" shaped affair four to six inches long. It may often be felt by rectum. As the intussusception crosses over from right to left the mass is under the liver and is hard to palpate. This is early in the disease, and careful palpation of the right upper quadrant must always be done in suspected cases.

In the subacute and chronic cases the diagnosis is more difficult, but fortunately, here, the early diagnosis is not of such vital importance. In these cases vomiting may be only occasional or absent, as is also the pain. The symptoms of obstruction are not prominent. The presence of tumor is the chief diagnostic point with usually a certain amount of mucous diarrhea, or even blood.

The acute cases, however, are the greatest in number, and here the early diagnosis is the prime factor in determining the prognosis of this grave surgical emergency. The common-

est mistake is to regard the vomiting, with bloody or mucous stools, as an enterocolitis. The finding of the tumor is most important, and careful abdominal palpation should always be done, and also as part of this, a rectal examination. The history obtained from the parent is very suggestive, and should never be disregarded. Once the diagnosis is made, operation is the only treatment. It is unwise to waste time in giving enemata.

The mortality for the 72 cases in this series is 41%, but if recognized early and operated on promptly, the death rate is very low. Of the 30 deaths, only four occurred in those operated within twenty-four hours after the onset of symptoms. None of the cases where the intussusception could not be reduced, and an enterostomy or resection was done, recovered. Clubbe, in a series of 253 cases, performed a resection in 16 cases. Of these 16, only two recovered. He has collected from the literature, 16 cases of recovery following resection for intussusception.

ACUTE APPENDICITIS.

In this series of 223 cases, the age distribution corresponds with that in series collected by other writers. That is, the disease is relatively rare in early childhood, and especially rare under two years of age. Cases occurring in older children, that is, over 10-12, present about the same problems as in the adult. The classical symptoms of pain, localized tenderness, vomiting, fever, and constipation, may be present, and the diagnosis is easy. But especially in younger children, the localization of pain and tenderness, even though present, is hard to establish. The child, when asked, will nine times out of ten, point to the umbilicus, and any attempt at palpation is likely to be unsatisfactory and unreliable. Vomiting is nearly always present, and when associated with fever, constipation, and pain, is usually indicative of appendicitis. The pain may cause merely an irritability on the part of the patient, and this, with the vomiting and constipation, often cause the parents to give too frequent doses of castor oil. When this type of onset is seen from 24 to 48 hours after the castor oil has been given, it presents no difficulty in diagnosis, and has come to be called the "castor-oil appendix." In a series of 50 cases of ruptured appendix, taken at random, from the whole series, 35% had had a vigorous cathartic given either by parents or physician before admission to the hospital. And this "home treatment" has played a large part in the high mortality rate of the disease.

The white count is of considerable help, as it is usually high, 15,000 to 20,000. The fever is likely to be 100° to 102°; the pulse elevated. A great deal may be learned, sometimes, by the thoracic type of breathing, and the disinclination of the child to move the trunk or legs. The flexion of the right thigh is a not uncommon sign, and leads to confusion with hip disease. The rectal examination should always be made, for in this way it is often possible to detect a mass. Greater tenderness on the right side than on the left is especially suggestive.

Conditions in the chest, especially the pleurisy accompanying a right pneumonia, or pericarditis with effusion, must be differentiated; also an early meningitis, and renal conditions, especially pyelitis. Intestinal upsets rarely have such severe pain or so high a blood count, but generally higher fever. It should be remembered always that a low count may mean only an overwhelming infection.

In any suspected or doubtful case, rest in bed with cleaning out by enemata should be tried, followed by operation if this treatment gives no relief, for it seems safer to intervene too early rather than too late.

General peritonitis occurs earlier and more frequently than in adults, and though the mortality is high in these cases, 33% in 36 cases of ruptured appendix with general peritonitis, it is less than in adults.

In children under 6 to 7 years old, the outlook is poorer than in those of 7 to 12 years. For all ages, without a general peritonitis, the mortality was 9%. This is a high rate; and an earlier diagnosis would greatly reduce it. The large percentage of cases that had had vigorous catharsis before admission in the hospital has been mentioned.

CHRONIC APPENDICITIS.

From hospital point of view, it is largely, in fact almost entirely, a matter of history. We believe it far safer to take out an occasional appendix that the pathologist says is normal, than to discharge a child who gives a history of one or more mild attacks, especially if the child has been seen in one of these attacks by its physician. There have been 195 such cases, with no deaths, and in the very large majority of cases it has been possible to follow up, the later results have been very satisfactory.

Acute peritonitis in children over two years of age is practically always due to appendicitis. There are other conditions which may be mentioned, though the possibility of preoperative diagnosis is difficult.

In cases of pneumococcus peritonitis the diagnosis is generally made at operation when a large amount of free, creamy pus is found, without the colon bacillus odor or signs of localization. To look for the appendix and try to remove it, will generally destroy the only chance of recovery, so that the best means of treatment is merely to insert drains. In these cases the mortality has been over 80%. In the other types the mortality is also high, 70% in this series. The causative agent may be a variety of organisms: streptococcus, staphylococ-

cus, and other pyogenic bacteria; also obstruction from internal strangulation; volvulus; extension from abscess about diaphragm; liver abscess; and occasionally gonorrheal salpingitis resulting from vulvo-vaginitis. Acute peritonitis in childhood is a grave condition no matter what the cause, and operation offers the only chance of cure. Under two years of age, the mortality is exceedingly high.

TUBERCULOUS PERITONITIS.

This is a serious though by no means hopeless condition. From a surgical point of view the success that is often met with by a simple exploration is hard to explain, but it certainly exists. Of 35 cases operated on, 16 have died either while in the hospital or soon after discharge, a mortality of 45%. The end-results of all these cases have not been completely obtained, and I can give only approximate results.

There are two types: the one in which ascites is the predominant symptom; and the fibrous or adhesive type.

The former is more favorable, though less frequent. The onset is slow, with fever, gradual swelling of abdomen with signs of fluid, general and progressive wasting, and signs of tuberculosis elsewhere. Vomiting is rare, as are pain and tenderness. The bowels may be constipated or there may be diarrhea. This type is often benefited by operation, although why, is not known. A thorough course of medical care should be tried first.

The fibrous type is slower in onset and more chronic. Aside from the general symptoms of afternoon fever, increasing weakness, and distention of abdomen, the symptoms are due to many and varied forms of adhesions that form between the coils of intestines themselves, and between the intestines and viscera. The omentum is often greatly thickened, and there may be areas of dullness showing local collections of fluid.

The negative Von Pirquet skin reaction is of great value in diagnosis. The Von Pirquet reaction in children is positive sooner or later in nearly all cases, but a negative reaction almost invariably rules out tuberculous peritonitis. In the male, always examine suspected cases for tuberculous epididymitis, which not infrequently occurs by direct extension down a congenital hernia.

Operation is indicated in cases of doubt as to diagnosis, or to relieve obstruction. The patients are sometimes benefited thereby to a remarkable degree, but the younger the child, the worse the outlook. The best treatment of all is general hygiene. Tuberculin is of doubtful value.

The not uncommon result of attempted freeing of adhesions by operation is a fecal fistula that is very slow to close, and this fact must be borne in mind when considering operation.

Lastly, there are grouped several conditions such as retroperitoneal abscess, ruptured mesentery, ruptured viscus, and other traumas, mesenteric thrombosis, megacolon, subhepatic abscess, and the various rare abdominal tumors, such as sarcoma of ovary and kidney, and Gaucher's disease.

There are in all 35 cases in this last group, with operative mortality of 45%. Severe visceral injuries in children have grave prognosis, as the operative shock is great and not well borne. The ultimate prognosis in cases of new growth is bad, benign growths being very rare. There were 12 cases of sarcoma of kidney; four of ovary; three of omentum; one of liver; two of adrenal; one of bladder. In the group of benign growths there were two cysts of mesentery, and two of the ovary. Solid tumors in children are practically invariably malignant.

Diagnosis	Total Cases	Deaths	Mortality
Umbilical sepsis	17	8	51%
Malformation			
1. Imperforate anus	27	5	18%
2. Other	12	12	100%
Pyloric stenosis	66	6	9.9%
Intussusception	72	30	41%
Intestinal obstruction — other causes	20	10	50%
Appendicitis			
1. Acute	122	11	9%
2. Acute with abscess	65	6	9%
3. Acute with generalized peritonitis	36	12	33%
4. Total	223	29	13%
Chronic appendicitis	195	0	0
Generalized peritonitis			
1. Pneumococcus		6	83%
2. Other organisms		7	70%
3. Tuberculosis		11	34%
Other abdominal conditions		16	45%
Total surgical admissions	4,748	381	7.6%
Total surgical deaths			
Total abdominal cases	738	142	19.2%
Total abdominal deaths			

The "abdominal" deaths are nearly 40% of the mortality for the Service. If there is included in the "abdominal" cases the 1064 hernias with three deaths, the "abdominal" mortality is 8% instead of 19.2%.

CONCLUSIONS.

Abdominal surgery in infants and children is a large and important field. The figures in the preceding table are perhaps discouraging. The mortality in such conditions as malformation, tumor, and general peritonitis, must nec-

essarily be high. The greatest hope lies in reducing the mortality in such conditions as acute appendicitis and intussusception. Acute appendicitis is the largest class of cases considered, and a mortality of 13% in 223 cases is surely high. But here, earlier diagnosis offers the best chance of improving these figures. Acute appendicitis and intussusception seem to us to be more frequently overlooked on the outside than should be the case. The acute abdomen in children is by no means a rarity; the most important fact that influences the prognosis is an early diagnosis and operation.

REFERENCE.

[1] The Diagnosis and Treatment of Intussusception. Charles P. B. Clubbe, 2nd edition, 1920.

REMARKS UPON CONSCIOUSNESS IN THE EPILEPTIC FIT.*

BY L. PIERCE CLARK, M.D., NEW YORK.

IN previous studies upon the psychology of the epileptic fit it has been pointed out the essential fault in idiopathic epileptics is an imperfect development of the instinctive life which underlies the emotions, so that the individual epileptic who possesses such a character defect has an intensive egoism, is supersensitive and suffers from an enduring emotional poverty. In consequence, he is unable to withstand the ordinary stresses of life without epileptic reactions of varying grades of severity.

Ordinarily, the epileptic fit has been defined as a loss of consciousness, attended with or without a convulsion, as the case may be.

Is there, strictly speaking, a loss of consciousness† in the epileptic fit? On studying more closely this seeming truism we question its validity. On specific investigation into the slighter grades of *petit mal*, we find that one patient makes the statement: "When a *petit mal* occurs, I can usually control myself and go on talking or continue whatever I am doing, and the *petit mal* is not apparent to others; there is a sort of turmoil in my mind. This lasts only a second, and afterwards I feel the same as I did before." Another patient says, "I feel intently aware of myself, and a feeling of wonder comes over me; I think, 'Why am I here? Why is the world, anyway? How did I ever get here?' This feeling lasts but a few seconds. It never occurs when I am actively engaged in work in which I am genuinely interested, but comes on between times when I am doing nothing." A third patient states: "During the confused spell I have a feeling that I must not let anyone know there is anything unusual, and that I must retain my poise at all costs. These spells are liable to come on at any time, no matter whether I am busy or not. During it I am thinking of what I intend to do, or of something I should like to accomplish. It may be some problem that comes up during the day, or it may be some task immediately at hand at the time the spell comes on. I feel a desire to keep myself intact. Consciousness, so far as outside affairs is concerned, is suspended, and my attention is directly turned in upon myself." A fourth patient states: "Following several light spells, or even as a spell comes on, I feel that I must not let anyone see what is going to happen. I am aware of all that is going on about me but cannot take part nor have I any desire to do so. I am inclined to think that there is more or less of a disagreeable feeling about these light spells, but I cannot state definitely just what this disagreeable part is. At other times, I feel that no matter what happens I know it is going to be that way, and that if a person speaks I know just what is going to be said. In fact, I feel I have the ability to foretell events and otherwise regard myself as a superior being at such times. On the other hand, there is another feeling that follows mild disturbances and that is one of being wrong about everything; no matter what I do or what is being said or done about me, I have a feeling that I am in the wrong. This feeling has come up only recently and follows a series of mild disturbances." Still another patient states: "I could always control these attacks if I really wanted to, but I let them come up. I let them come and then I feel better. Afterwards, I feel quiet, soothed and free from tension. They are a deep-rooted satisfaction to my soul."

One of my boy patients, suffering from a continued and enduring epilepsy, gave a description of his *petit mal* attacks as follows:* "As the absent-minded spells come on, I dream of something far off—the ideas are all mixed, just like a dream when I am asleep, or when I am at a party and lots of boys are

* Read before the New York Neurological Society, January 4, 1921.

† I am using the term consciousness in the sense of "a state of being aware of one's mental acts or states" (Century Dictionary).

* Case reported in detail, "Nature and Pathogenesis of Epilepsy," N. Y. Med. Jour., Feb. 27, to March 27, 1915, Case V.

around, or when we are playing Indian. Usually I am flying in air, or something. I am having a smooth sailing about. It is never unpleasant, but just fine. The harder and longer the dreamy turns are the more satisfied I seem to be. I wander, float away; maybe I glance against something and then shy off again to float about in a different direction. I only remember the beginning and the ending of the hard ones (grand mal), but in the moderate sized ones I get the most definite dreams. I take up the things around me and make the most fantastic and queer things out of them; I think people moving about me are really trees, and their talking is running water and wind blowing about. As I gradually go into the deepest part of the severe attack the dream grows more confused and mixed up; it gradually fades out, and I simply lie in the air. I float without moving, and my feelings are as though I don't care about anything; it is so peaceful and quiet, and I am very happy. I feel as though I want to keep on going, as though I didn't even have to breathe. It seems as if the attacks come over me and enfold me like great floating blankets."

It seems hardly necessary to comment upon the self-anamnesis in the attacks as being a beautiful, almost allegorical description of a return to infantile instincts and desires.

Another instance is a young woman whose grand mal epilepsy has been in evidence since puberty.* She volunteered the information that the minor attacks were most desirable, and were encouraged when she was alone, and particularly when in bed. She then felt that they were pleasurable, quieting and soothing, as though going to sleep; she pulled the bedclothes over her head to enjoy them to the utmost, and if anyone came into the room, shook her, or distracted her attention, she felt irritable and said, "Can't you leave me alone? I wish you would not bother me." A further description of vaguely remembered things that happen to her when actually in a sensation is almost identical with the boy's account just given. In sensations of moderate severity, she invariably says: "Yes, yes, I am quite all right; why, certainly,"—there being a manifest desire to fend off anyone attempting to do anything for her that might tend to abort the sensation.

* "A Further Study of Mental Content in Epilepsy," Psych. Bull., October, 1917.

Another epileptic patient of mine,† a man in the thirties, experienced an unpleasant sleepy feeling after dinner. At such times he would allow himself to "drift off" into a reverie. He then feels as if he goes off into space, as if he were still only vaguely conscious of something about him and knows where he is and what he is doing. This detachedness from reality and the states of lethargy are but heightened states of subjectivity in which the inner life dramatizes itself, somewhat like day dreams and the states of mental abstractions which are common enough in those not epileptic; but that which gives them a distinct pathologic import is their unmanageableness—the slipping away at times from conscious control at the behest of something in him "that demands" appeasement, in other words, *unconscious demand* makes itself felt and he has an epileptic reactive setting of an otherwise common enough every-day abstraction (minor automatism). He often experienced a sense as though people were about as in a dream. The scene and visualized sensations were of the character "as though he were in the center of it all, and all things centered about him." The general physical sensations were always unpleasant and distressing when translated into conscious terms or when he was fully free from them. Yet while being experienced they were all pleasant and harmonious.

It is perfectly obvious that the motive of the whole foregoing type of reaction exquisitely demonstrates the unconscious motivation of the whole mechanism of the epileptic reaction, namely, the desire to abolish contact with reality of the external world and gain access to the infantile life of personal pleasure and freedom.

In another male patient, just before the sensations are to occur, he often feels a lack of rapport with those whom he may be with and a sense of indifference or boredness follows, in which he feels a heightened sense of his own body and mind, and a "detachment from others about him" (increased subjectivity.)*

We freely admit that the mental content is not always pleasurable on its manifest content, although many of the citations here bear that significance, but that its ultimate or deeper significance supplies as egoistic a satis-

† "Clinical Studies in Epilepsy," 1917, p. 37.
* "Clinical Studies in Epilepsy," 1917, p. 80.

faction as the essential analysis of dreams has proven.

From this we must infer that instead of there being a loss of consciousness in totality, the subject-consciousness is really increased. It is true that object-consciousness or awareness of one's *surroundings* is greatly or entirely lost, but a heightened sense of consciousness is found to be present as regards the *awareness of self*. From the very nature of the fit one might naturally expect this to be so. That is, if the breadth of the field of consciousness is narrowed, that part which remained would be expected to be more intense. We may therefore rightly infer this clinical observation to be true. In cases of more severe epileptic reactions, where an individual may be unable to report his subject-awareness, we may judge by his appearance and manner that he is in a state not dissimilar to that experienced by individuals who are able to translate their feelings from the twilight state. In still deeper grades of disordered consciousness, as in the grand mal, we infer from the content we have been able to get during the deep coma or lethargy, that such epileptics have so narrowed their subject-consciousness to the most intensive egoistic concern as to make it comparable to that at birth or earliest infancy. If the patient does not voluntarily speak, he will often answer questions put to him as to what he is doing, what he is thinking, etc., and almost without exception he will answer in disjointed sentences, in the optative mood, as "I am trying to," "I want to," "I'd like to," "I wonder," or "I thought" so and so.

It is therefore quite understandable why self-awareness should be increased in the milder attacks because of the narrowing of the field of normal consciousness. As the state of self-awareness as we have been considering it, disappears in grand mal, there is an inflation or disturbance of the real unconscious, motivated by such an egoistic drive that it is manifested in acts of violence in the automatism, or is engrossed in a most intensive egoistic concern, as shown in fragments of thoughts or states of lethargic *allmacht*. The condition is then one of complete power over the state of being after an entire abolishment of all phases of reality.

The state of epileptic reaction, then, is an involution of the normal development of consciousness. The latter is gradually evolved out of the egoconsciousness to that of a wide and rich combination of both subject and object consciousness, or a unified composition of both. If we assume the foregoing to be generally true, and that the epileptic reaction is an involution of the slowly built up normal consciousness of every-day life, one may understand the enormous psychic importance of the fit. First, it has a definite deteriorating influence upon the power of sustained interest and attention, and the tranquil orderliness of the normal objective mental life. As a result of this involution previous memories and sustained attention fail, even though only mild seizures occur. In this assumption we can understand the often indifferent attitude which the epileptic assumes relative to recovering from his disorder, as each attack refreshes and satisfies his cruder egoconsciousness and enriches his egoistic interests. To ask him to forego this unconscious self-gratification and give up his morbid purpose often falls on disinterested or deaf ears. Our continued appeal must therefore be along lines of intensifying his personal satisfactions in every-day life comparable to that which he derives from his epileptic habit. Nothing less will avail. It also makes clear that possessing such a relatively simple and crude pattern of personality, the epileptic is loath to accept a life of self-denial and to give up his egoistic concerns which yield him so rich but so destructive a return.

Therefore, if essential epilepsy is really an organic disease but without demonstrable microscopic pathology of the brain, we may steadily refine our conception of the symptomatic picture of the disease. Thus in somatic and phychologic studies we may arrive at a more comprehensive therapy for the disorder. It is rather remarkable that the practical conclusions of our investigations make but more patent the most modern empirical plan of therapy of today. The signal advantage gained in these studies is to make more precise and insistent our points of attack and to follow them to the logical goal for a broader and more general therapy for the epileptic.

PREMATURE RUPTURE OF THE AMNIOTIC MEMBRANES.

By Allen T. Moulton, M.D., Boston.

Premature rupture of the amniotic membranes is probably the most common accident occurring in pregnancy; occurring in about 13.5 per cent. of all pregnancies and seems to be a little more frequent in primiparae. In a great majority of cases premature rupture of the membranes is unattended with any grave complications. On the other hand, in a certain number of instances, especially in elderly primipara, we encounter, at times, serious dangers for both mother and baby.

In dry labor the duration is unquestionably prolonged, vaginal and cervical lacerations are much more likely to occur, puerperal infection is more frequently seen and in a certain number of cases, although infrequent, uterine rupture results from long continued labor. The child at once becomes a possible victim from intercranial hemorrhage or asphyxia. Dry labor carries with it an infant mortality of about 3 per cent.

The amniotic fluid is a clear fluid of albuminous consistency, alkaline in reaction, and has a specific gravity of about 1.008. It varies in amount in normal pregnancy from 2 to 2½ liters. It is enclosed in a thin, membranous sac, the amnion and chorion. As to its origin authorities differ. The most practical theory is that it is derived from the maternal fluids which have been modified by the amniotic epithelium. It is doubtful that the foetal kndneys play any part in its formation under normal conditions. Its function is to furnish fluids to the foetus during pregnancy and to maintain a constant temperature for it in utero. It serves to prevent the foetus from receiving external shocks and also prevents the formation of adhesions existing between the foetus and amniotic membranes. In labor the membranes with its enclosed fluid serve the important function of dilating the cervix.

Premature rupture of the amniotic sac may occur at any time during pregnancy but is more frequently seen in the latter period. It may result from the most trivial cause, and at times without any apparent cause, sometimes occurring in patients who are lying quietly in bed. Frequently seen in association with premature rupture of the membranes are pelvic deformities and abnormal presentations. Among the most common are contracted pelves. It is frequently seen in breech and occipito-posterior positions, twin pregnancies and hydrannios. Among the causes for premature rupture of the membranes are violent coughing, vomiting, and straining at stool. Automobile riding and coitus in the latter months of pregnancy certainly play a part in causing early rupture.

When rupture occurs labor may begin within a short time. This is not, however, a general rule. There may be an elapse of days or weeks after rupture before labor begins, much depending on the irritibility of the uterus at that time and the period of pregnancy in which rupture takes place. Patients who rupture their membranes near term usually start in labor shortly following rupture.

SYMPTOMS OF PREMATURE RUPTURE OF THE MEMBRANES.

The most pronounded evidence that a pregnant woman has of ruptured membranes is a sudden gush of fluid escaping from the vagina. This may vary in amount from a teacupful to an ordinary hand basinful, or there may be a gradual dripping of fluid from the vagina. Patients sometimes notice that the abdomen feels much smaller. One patient whom the writer recalls who was having considerable pressure dysponea ruptured her membranes early and felt positive of it as she could breath with less difficulty. This is an inconstant sign, however, much depending upon the amount of fluid which has escaped. If the rupture is low and the head high a large amount of fluid will escape. If the rupture happens to be high up in the lower uterine segment a valve-like condition may result and only a small amount of fluid will escape. Any abnormal amount, however, of watery vaginal discharge should lead us to suspect that the membranes have ruptured until otherwise proved. Two conditions may simulate ruptured membranes, i.e., an overfilled bladder and hydrorrhoea gravidarum. An overfilled bladder can usually be detected by careful examination of the bladder no change in the size of the abdomen, and the presence of intact membranes.

HYDRORRHOEA GRAVIDARUM.

Hydrorrhoea gravidarum is a disease of the decidual glands in which the glands become hypertrophied and their ducts remain open; as a result of chronic inflammation a fluid is poured out between the amnion and chorion where it makes its escape at the os iteri. This may simulate ruptured membranes and at times it is impossible to differentiate between them. There is no decrease in the size of the abdomen, labor does not come on, and there is no dilation of the cervix. Ballotment is obtainable on vaginal examination.

MATERNAL COMPLICATIONS FROM DRY LABOR.

Probably the most common complications resulting from premature rupture of the membranes are septicemia, vaginal and cervical lacerations, tetanic uterus, uterine rupture, and exhaustion of the patient may also occur. One or all of these may occur in the course of dry labor. As a result of a prolonged labor a tired uterus may develop which may not contract well after expulsion of the placenta. This may give rise to a post partum hemorrhage.

Septicemia occurs quite frequently, probably in proportion to the amount of vaginal interference which becomes necessary, either instrumental or from examination. As to the length of time following rupture and the onset of labor having any bearing on the frequency of infection, authorities differ from their own personal experiences. Demelin, in a study of 513 cases, found that there was an increase of .8 per cent. where labor began within twelve hours after rupture of the membranes; to 11.26 per cent. where five days had elapsed. Dorman and Lyon, in a study of 270 cases, did not find that there was a proportionate increase of infection after the membranes had ruptured some days prior to the onset of labor. Unquestionably any interference from below, either by vaginal examination or operative delivery, increases the risk of infection—a strong point in favor of rectal examinations in all dry labors. Probably about 25 per cent. of dry labors which terminate in forceps delivery will show some evidence of sepsis, running a temperature ranging from 101 to 103 for a week or ten days, then gradually returning to normal. Phlebitis is not uncommon. Sepsis may be of the sapremic, pyogenic or streptococcic variety. The acute fulminating fatal sepsis is not often seen. Lacerations of the cervix and vaginal tissues are prone to occur, owing to the necessity of operative interference. About 33 per cent. of all dry labors terminate in operative delivery. Cervical tears are frequent as dilatation is not complete, and because of the disproportionate head trying to overcome the resistance in the absence of the bag of waters. Any degree of tearing may result from the slightest laceration to those extending up to or beyond the vaginal junction. In some instances they extend into the lower uterine segment opening the base of the broad liagament, causing a profuse hemorrhage or fatal peritonitis.

TETANIC UTERUS.

As a result of prolonged labor especially where we encounter a rigid cervix which does not dilate readily the uterus fails to relax between contractions as a result of fatigue, and a tetanic condition of the uterine muscles results. Similar to this condition is a form of dystocia where a constriction occurs between the upper and lower uterine segments. This constriction results from a contraction of a ring of muscle fibers which exist here. This muscular ring was extensively studied by Dr. Bandl and called after his name, *i. e.*, Bandl's Contraction Ring. The force necessary to overcome the resistance of this ring may result in uterine rupture, either spontaneously or as a result of operative delivery or an attempt at dilatation.

Exhaustion is commonly seen in patients who have had a long tedious dry labor. It is evident by the blanched expression of the patient, the long, drawn features, weakness of the voice and gradual elevation of the pulse. Now in modern obstetric practice we seldom see patients dying from exhaustive labors as delivery is performed before this unhappy occurrence.

DANGERS TO THE BABY.

Intrauterine asphyxia and intercranial hemorrhage are by far the most common accidents occurring in the baby in the course of dry labor. This is attended with a mortality of about 3 per cent. Intrauterine asphyxia may result from any cause which interferes with the normal circulation existing between mother and baby, a common cause being a prolonged first-stage labor with intense uterine contractions or a uterus which has undergone tetanic contraction. Asphyxia results in this way: after rupture of the membranes the uterine interior is diminished in area and with it the placenta site. As a result the child received less oxygen and more carbon dioxide, stimulating the respiratory centers in the medulla, causing inspiratory movements in the baby which results in the aspiration of fluids or mucus and fluid into the bronchi, thus causing asphyxia at that time or a secondary broncho-pneumonia. Asphyxia may result from a prolapsed cord, or as a result of cerebral compression from a prolonged first-stage labor, the uterus constantly contracting against the foetus, driving its head against the undilated resistant cervix or pelvic wall, cerebral hemorrhage occurring causing vagus irritation, thus slowing of the heart whereby the oxygen supplied to the unborn foetus is diminished or abolished. Asphyxia may also result from compression of the cord by the descending head against the pelvic wall or from compression of the head in forceps extraction. This is more likely to occur from too long traction on the forceps without relaxation of the blades or from an improper application.

DIAGNOSIS.

The diagnosis of premature rupture of the membranes is usually made from the history of a sudden gush of fluid escaping from the vagina in the course of pregnancy with the more or less constant dripping of fluid from the vagina afterwards. Palpation of the abdomen will reveal the absence of fluid in the uterus if a large amount has escaped and the foetal small-parts are much more evident. If a vaginal examination is made, which should be done under the most rigid asepsis, the examining finger when introduced into the cervix will detect the absence of the usual amount of fluid which precedes the head and will come into direct contact with the foetus, and in vertex presentations the hair may be felt rather than the thin slippery membrane which we note with intact membranes. It is always well to inspect the bladder to detect any escape of watery fluid, as many patients in the latter months of preg-

nancy are alarmed that their membranes might have ruptured prematurely when in reality it is only the escape of urine from the bladder. Patients are much more likely to imagine that this has happened when it has not rather than have a real rupture of the membrane occur and escape notice.

TREATMENT OF DRY LABOR.

Before entering into the treatment of dry labor it seems well to mention the necessity of warning patients in the latter months of pregnancy of the possibility of premature rupture occurring and for them to avoid, as far as possible, the causes which may bring this about. Constipation, vomiting and violent coughing may be an exciting cause, and pregnant women should certainly avoid overexertion in any form. Riding in automobiles should be forbidden. This is carefully gone over by the writer to all his patients in the latter months of pregnancy. Regardless of the extreme care a pregnant woman may use to avoid this accident a certain number of patients will rupture their membranes early, and despite the watchfulness of the obstetrician and the use of extreme care, he will have to cope with one or more of the complications which are manifested in a certain number of dry labors.

To outline any precise method of care in a given case of dry labor is absolutely impossible, for each case may take on a different aspect as labor progresses and often those cases in which we are most apprehensive will terminate most favorably, and *vice versa*, those in which we feel the least concerned will suddenly give us cause for alarm. We may, however, mention a few facts which may seem in the minds of some to be overconservative, but will in a series of cases bring about equally as good results in both mother and baby. The writer feels that unless some imperative complication exists which endangers either mother or baby or both, a patient either primipara or multipara should be allowed to fall into natural labor, regardless of the length of time elapsing following rupture before the onset of labor. At one time when the Voorhee Bag first came into use most patients with premature ruptured membranes were induced. Admitting that the Voorhee Bag is the best artificial means we have at our disposal today for dilating the cervix, it is not without risk of infection and does not seem to lessen maternal mortality, but seems to increase fetal mortality. It does not always accomplish its purpose but when once introduced into the cervix subjects the patient to the added risk of infection. There is this to be said, however, that when we encounter a rigid cervix the introduction of the Voorhee Bag certainly accomplishes the purpose of softening the cervix, making it more readily dilatable. In some cases the induction of labor is absolutely necessary to safeguard both mother and baby and no other means at hand serve the purpose as well as does the Voorhee Bag. This is a conical shaped bag made of rubber which can be readily rolled upon itself and introduced into the cervical canal. Usually, in primiparae, gas-oxygen or primary ether anesthesia is necessary, but in multipara, unless the patient is extremely apprehensive it may be introduced without much discomfort. The patient should be placed in the lithotomy position and the index and second fingers introduced into the cervix. The bag is rolled upon itself and grasped with a long clamp and passed into the cervix beyond the internal os, so that the apex of the bag protrudes at the external os. It is then filled with sterile water by the use of a syringe and forms a V-shaped bag. This acts as a foreign body in the uterus, stimulating uterine contractions. The use of the Volcellum forceps on the cervix is not necessary for the introduction of the bag. The writer firmly believes that labor should not be induced unless some complication arises which endangers either the mother or the baby. Infections in the absence of vaginal examinations are not frequent following rupture of the membranes but are certainly increased following the introduction of the dilating bags. My plan is to allow all patients to fall into natural labor and if after eight or ten hours of good hard pains the cervix is not dilated completely, the patient is anesthetized and dilatation is completed manually. After eight or ten hours of uterine contractions, as is usually seen in dry labors, patients become exhausted and make poor risks for subsequent forceps delivery. Babies also are poor risks for forceps delivery after long exhaustive pains. Much better results will be obtained if forceps are resorted to early rather than late in these cases. We have the ever-present danger of a contraction ring developing in a fatigued uteri which is avoided if delivery is accomplished before the uterus becomes tired out. The cervix should be completely dilated and if a contraction ring is present, this also should be dilated as much as possible before an attempt to apply forceps is made. One should always bear in mind the frequency of posterior positions and if present, the head should be rotated to an anterior position. This may be accomplished in one of three ways. Manual rotation with the head high to an anterior position may be tried, or forceps may be applied with the head high and rotated to the front with the blades of the forceps, or the forceps may be applied to a posterior head and drawn down to the pelvic floor where it will rotate spontaneously after the method of Scansoni. An assistant is necessary to perform a satisfactory forceps extraction. He should stand to the right of the operator with the index and second fingers of the left hand introduced into the cervix above

the head, his right hand should grasp the handle of the forceps while the operator makes traction. A steady pull should first be made by the operator to see if the blades hold, assuming they are applied properly. Successive gentle tractions should be made, and after each traction the handles of the blades should be separated to avoid continued pressure against the head. The traction rods should not be dispensed with until the head appears at the perineum. In breach presentations the same rule as holds true in vertex presentations regarding lengthy first stage labor, complete dilatation of the cervix manually and deliver rather than trust to the patient to accomplish this. In breach presentations we have, in addition to the loss of the dilating bag of waters, the disproportionate breach to serve as a dilating wedge, which in primiparae is almost a mechanical impossibility.

After delivery and expulsion of the placenta a thorough search should be made for cervical and vaginal lacerations. They are almost invariably present and should be repaired. A ribbon retractor in the hands of an assistant works admirably well in exposing the cervix so that it can be properly repaired. Versions should not be attempted if possible to avoid, as there is always a possibility of causing a uterine rupture. It seems to the writer that in those cases where version has to be resorted to as in elderly primipara, deformed pelves, or an unengaged head, providing no vaginal examinations are made and in the hands of a competent person Caesarean section does not increase the risk of the mother, all things considered, any more than does internal podalic version and certainly offers a better outlook for the baby. The writer feels that although this remark is contrary to the practice and teaching of competent obstetricians, still there is weight of evidence in its favor. My collection of cases where it has been performed is not great, but those where it has been performed made an uneventful convalescence. Dorman and Lyon, in a series of 270 cases performed this operation 8 times with no maternal deaths. Vaginal examinations frequently and improperly made or made at all under the most rigid asepsis are a menace to Caesarean section. In 29 cases studied by Dorman and Lyon there was an increase in maternal morbidity of 52 per cent. where more than 4 vaginal examinations were made, as contrasted with 25 per cent. where there were no recorded vaginal examinations.

Pituritin should not be given at any time in the presence of dry labor even after the expulsion of the placenta for when it is given unless followed by ergot there is always a possibility of a secondary postpartem hemorrhage. If bleeding occurs from forceps delivery after the closure of all cervical lacerations and does not cease with the ordinary agents used, a packing firmly placed in the uterus and allowed to remain for fifteen or twenty minutes will usually cause the uterus to contract sufficiently to stop the bleeding. No packing should be allowed to remain in a postpartem uterus over twelve hours, and when removed after this time should be followed by an intrauterine douche.

In all dry labors one should be always mindful of the possibility of an asphyxiated baby. Plenty of hot water should be at hand either in the private home or hospital to use to immerse the baby in. The water should be warm enough to cause a distinct erythema on the child's body after being immersed. If the baby does not readily gasp for breath, mouth to mouth breathing should be done. Much better results are obtained from this method than are ever obtained by the use of cold water, the pulmotor, or the violent methods of resuscitation as laid down in the textbooks after Schultz, Byrd and Dew. These methods simply serve to increase the muscular exertion on the already shocked and asphyxiated baby. The writer personally never seeing any benefit derived from their use, and at best will never equal the success that is obtained from warm water and mouth to mouth breathing. This method properly performed has saved and will continue to save the lives of many asphyxiated babies.

SOME ASPECTS OF CANCER OF THE PROSTATE.*

BY ARTHUR L. CHUTE, M.D., BOSTON.

IN going over the last 200 cases upon whom I have done a prostatectomy I have found that in 35 of these cases, or 17.5% of the whole, the prostate was malignant. I have taken these 200 cases as they seemed to fall rather naturally into a group by themselves, likewise because of the fact that during this time neither my technique nor my views regarding the indications for operation have changed materially.

While in this group of 200 cases I have recognized 17.5% as malignant, I think it is more than probable that this figure underestimates the relative frequency of cancer of the prostate since some of the beginning cases show very little that is particularly suggestive of the condition, especially those in which the disease is associated with hypertrophy. I think it is more than likely that I have overlooked some cases in this series and that the actual incidence of malignancy may have been somewhat higher than 17.5%. As these operations were carried out upon both hospital and private patients, taken in order, I believe the figures represent pretty well the relative frequency with which

* Read before the American Association of Genito-Urinary Surgeons at the meeting in Richmond, May 2, 1921.

we may expect to find malignant disease in any considerable series of cases of prostatic obstruction. These figures practically agree with other series that have been reported, in which malignant disease has been recognized in about 20% of the cases.

Although these malignant cases constitute, according to my figures, a very considerable proportion, about one-sixth of the total of cases of prostatic obstruction, it is my experience that there is a great divergence of opinion among genito-urinary surgeons, concerning the indications for operation in these cases and also little agreement as to what sort of an operation it is wise to carry out in the cases where operation is indicated. I can perhaps best illustrate this attitude by certain incidents that have come under my notice, some of them within a relatively short time. For instance, a little more than two years ago I operated upon a man 82 years old with an extensive cancer of the prostate as felt by rectum; this man had an over-distended bladder, nearly up to his umbilicus. A man whose opinion I value highly had advised against any attempt at operation though catheterization was most difficult, the idea being, as I understood it, that operation would probably not be worth while. This man's bladder was, however, drained as a preliminary step and then under spinal anaesthesia as much of the malignant disease as I could get was removed through a perineal incision. This patient, who is alive 26 months after operation, was relieved of his retention and has attended to his business a considerable part of the time since operation. A rectal examination of this man's prostate made quite recently showed the sharp angular edges where the malignant tissues had been cut at the time of operation; this angularity existing 2 years after operation seemed to me to indicate the relatively slow progress of the disease locally. This patient has, however, had some increase in his obstruction of late but still has little in the way of cachexia. I feel that the palliation he has had has been well worth while, and I even stand ready to advise the re-removal of his growth if his obstruction to urination increases much. This re-removal of a malignant prostate is a point to which I shall refer later.

Again, last summer I removed by the perineal route as much as I could get of a malignant prostate that had been partially removed by the suprapubic route about a year before. This operation had been done by a man whose opinion and work I greatly respect, but who felt that further operation was in this instance useless and would do harm rather than good. I did the second operation because of a recurrence of the obstruction attended with more or less bleeding. The patient has been much more comfortable than he was; had practically no residual when I last saw him; has attended to his business, and has made a certain number of business trips. He has also been able to play golf with reasonable ease. This case can hardly be spoken of as a second removal of a cancerous prostate since the area from which I removed the malignant disease was probably below that reached in the first operation. Two other instances have come under my notice within the last few weeks where men with a considerable experience, when unexpectedly confronted at operation with a carcinomatous prostate practically made no attempt at its removal.

I can readily understand this attitude regarding the operative treatment of cancer of the prostate though I do not sympathize with it. It is, I believe, the very natural result of the contrast between the wonderful results obtained by the removal of the benign prostate and the relatively disappointing results obtained by the removal of malignant prostates. When one compares the results obtained in the treatment of these two classes of disease, there is little wonder that the cancerous cases seem hardly worth doing from the standpoint of cure. Cure is, however, not possible in all conditions; in some we must be content with palliation and a semi-occasional cure, and if, in many cases of a disease that is necessarily fatal eventually, we can prolong life for a year or two and especially if we can add to the patient's comfort, I believe it is well worth while. When looked at from this point of view the subject I believe assumes a different aspect.

It has been my experience to encounter cancer of the prostate under three conditions: first, in cases where it has produced symptoms because of the obstruction it has offered to urination; second, where it has produced pain due to pressure, and finally where in relatively young men it has produced vague urinary symptoms that have led to an examination of the prostate and its discovery, accidentally, so to speak.

It is my belief that when a carcinoma of the prostate is causing any particular obstruction to urination we should remove as much of it as it is possible for us to do, just as we would in the case of a non-malignant prostate causing obstruction. That while we cannot hope to cure the condition except in the rarest instances, we can, in many cases, give a degree of palliation that is well worth while and in fact actually lengthens life, for in a very considerable proportion of unoperated cases of cancer of the prostate, the patient does not die of the cachexia of his carcinoma but the fatal result is in a large measure due to the same pyelonephritis that we see in other instances of urinary obstruction.

I have not infrequently had men object to the removal of a carcinomatous prostate that was producing obstruction to urination, on the ground that the inguinal glands were involved; of course, when one considers the operation

from the point of view of palliation the presence of inguinal glands even if known to be malignant, is not a bar to operation. Another objection has been the fear that the incision could not be made to heal, a groundless fear, I believe, when the proper technique is employed.

In those instances of cancer of the prostate where the patient's greatest complain is of pain either in the region of the sacrum or in the thighs, the indications for operation are less clear than in the cases that produce obstruction to urination. In some of these patients, however, the removal of such malignant tissue as we can get is followed by an amelioration of the pain. I am inclined to believe that we are justified in cases of this sort in removing as much of the malignant tissues as we can get especially if at the same time we implant radium in the walls of the cavity. No operation would be indicated in cases where it seemed probable that the pain in the legs was the result of a metastatic involvement of the spine. In my own cases of this type the pain has apparently been due to a lateral extension of the disease and the consequent pressure.

In the third group of cases, those in which one comes upon cancer of the prostate accidentally so to speak, where it is not producing either urinary obstruction or referred pain but just a feeling of discomfort such as is occasionally found with chronic prostatitis; in these cases the indication as to what course we should follow is far from clear. In general we know that the course of the disease, if unchecked, is fatal though it may often be slow; that the removal of the tissue may be attended with a long respite and possibly in the very rarest instances by cure; also that the use of radium, the application of which operation greatly facilitates, inhibits the disease in most instances and probably actually cures it in some cases. All this would argue for operative interference in these cases. On the other hand it has been my experience that some of these cases, of which I am glad to say I have only seen a few, have not done well following operation but have gone on rapidly to a fatal termination.

In the removal of the malignant prostate there are three procedures that I have found useful. I have not made use of the radical operation devised by Young for the reason that I have found few cases to which I thought it was appliable. To use it, I have felt, one must be sure that there was no metastasis. That it was too radical to use unless you would practically be sure that there was no extension of the disease and that you could remove it all.

In a small proportion of these cases one may remove a malignant prostate by suprapubic enucleation. This is possible, however, only in the less advanced cases where the growth is pretty well within the capsule. In a considerable proportion of the instances where I have removed a malignant prostate by the suprapubic route, I have failed to recognize the type of disease with which I was dealing until the time of operation; it has been, in fact, the difficulty of enucleation that has first called my attention to its nature. In this series of 35 patients I operated on seven cases by the suprapubic route. All these patients had had a preliminary suprapubic drainage on account of their poor condition. In five of these cases I had not recognized that the condition was malignant before the time of operation. In two the condition had been recognized as malignant previous to operation but as it has seemed best to do a preliminary drainage on these patients it seemed wisest to attempt the enucleation through the suprapubic incision.

In instances where a preliminary suprapubic drainage has been carried out and yet in which the prostate is so dense and firmly attached that it cannot be enucleated from above, I have been accustomed to make use of a combined method. This I employed in six of the patients in this series. In this procedure one makes the usual perineal incision and cuts and bites out all the malignant tissue that he can get. Much more accurate use of the prostatic punch may be made in this way, since it can be introduced through the perineal wound but used under the guidance of the forefinger, introduced through the suprapubic wound. The perineal wound facilitates the application of radium and the suprapubic opening offers a splendid chance to control hemorrhage by packing, should that be necessary. A previous suprapubic incision in no way complicates the perineal removal of a cancerous prostate, or benign one for that matter; if anything, it facilitates it.

While the two methods just mentioned are applicable to the removal of a certain number of cancers of the prostate, the method which has the greatest applicability is a slight modification of the Young perineal operation for the adenomatous prostate. I employ the classical position, incision and dissection of the perineum until I reach the prostate. Then, however, I make a transverse incision into the prostatic tissue, which I find better adapted to the purpose than the antero-posterior incisions usually employed. This transverse incision allows one to turn back a flap of tissue that helps materially to protect the rectum from injury. One should then proceed to the enucleation of the prostatic tissue. Exceptionally, this may be done with the finger alone. Often, one may use a rather dull periosteum elevator to advantage, cutting with its edge. In the majority of instances one must nibble away with a rongeur forceps, a little at a time, such of the disease as he can get. In order to relieve the obstruction to urination it is especially necessary that the dense tissue that sur-

rounds the bladder outlet be removed very thoroughly. This can be done sometimes with curved scissors, sometimes with the prostatic punch, and sometimes with rongeurs. It is my custom to put a catheter in the urethra and perineal tubes through the wound. For the last year or more it has been my custom to drive small needles containing radium into any little masses of suspicious tissue that remained. These needles are ordinarily left in place from 24 to 48 hours, depending upon the thickness of the tissue left; the dose of radium used has usually been 25 milligrams.

The convalescence in cases of this sort is not different from the convalescence following the ordinary prostatectomy for benign disease except that I think malignant cases, as a whole, show an unaccountable lack of vitality not seen in the ordinary benign cases. In 26 of this series of 35 cases the operation was carried out in the above manner. In seven of these cases spinal anaesthesia was used rather than inhalation anaesthesia; this, in spite of the fact that the position with the hips elevated is not the ideal one for this form of anaesthesia.

In our palliation of this condition it is even possible to re-operate upon some of these patients who have a reoccurence of their obstruction. I have done this in one instance only though I have suggested it in several. The operated case concerned a man operated upon in 1914 for a prostate that was clinically and microscopically malignant. A few months before I saw him in 1919 his obstruction had recurred and as he had little cachexia, I again did a perineal prostatectomy. Following this second operation he had very little control of his urine but some little time after operation his general condition was very satisfactory, although he has not been heard of recently.

As to the results in this series of cases one man of 80 odd years died in the hospital; a death one may fairly consider the result of operation; four died in from six weeks to six months after operation; they all left the hospital but were never more than convalescent; they died without having any adequate increase in comfort from their operation; they may be considered failures as far as giving any real relief is concerned. On the other hand in three of these five cases there was retention with great difficulty in the use of a catheter and they would have had to have a cystostomy or be allowed to go on without any attempt being made to give them relief.

Of the thirty remaining cases seven are known to have died, one two years after operation; he died as the result of an automobile accident, but I regret to state that his automobile trip was being made so that he might re-enter a hospital under my care. The autopsy showed that several ribs were fractured and that the fractures were at the seat of metastatic foci of carcinoma; no cancerous foci were however, found in the bones of his fractured legs. In this patient there had been a lateral extension of the disease in the pelvis. There were metastases in his lungs and one in his heart muscle; this was a patient on whom I carried out a suprapubic prostatectomy, enucleating the prostate in practically one mass. The removal was difficult and was my first intimation that this man's disease was carcinoma. The nature of this growth had not been recognized as at examination it was covered with a soft esdema, a condition that often obscures the typical feeling of a malignant growth. Another of these patients lived two and one-half years after operation and was able to keep at his work, that of a crossing-tender, up to within three weeks of his death. It is an important thing with a laboring man, suffering from long drawn out and necessarily fatal disease to be able to keep him at work as long as possible. Three died of intercurrent disease; it was expressly stated of two that they had been free from urinary symptoms; nothing was said regarding this in the case of the third.

The sixth died of a recurrence nine months after operation. He had had a relatively short period of only moderate relief. The seventh died a few months after operation but the cause was not stated. I have lost sight of four of these patients. I presume they have died. Nineteen of this list of thirty-five patients were known to be living within a short time. One of these, the first of this series, operated upon three years ago was reported as well within a few weeks. Four are alive two years after operation; one of them should be re-operated but the others are comfortable; another operated upon a little more than a year ago and seen within a short time says that he never was better; this man was treated with radium at the time of operation, as nearly all of the recent cases have been.

Of thirteen cases operated upon within a year five are reported as being comfortable. One is very uncomfortable with what I believe is without a doubt a local recurrence; another had a pathological fracture of a femur some weeks ago. X-rays of this were reported as showing metastatic carcinoma at the side of fracture. The others have been operated upon too recently to allow us to draw any useful conclusion regarding them.

I have two cases to add to this number that are encouraging; they did not come in this series of cases but were both operated upon in 1911. Both presented themselves because of urinary obstruction. The first case was clinically carcinoma of the prostate. The late Dr. Arthur T. Cabot concurred in the diagnosis; all the tissue I could get was removed by the perineal route; it was macroscopically and microscopically carcinoma. I saw this patient several times during the past winter. He is the picture of health and has no symptoms what-

ever. The second patient was likewise operated upon in 1911 for what was clinically and microscopically carcinoma. I examined this man in 1917 at which time he was apparently perfectly well. He was reported as well at a later date though as no note was made at the time I cannot give the date.*

These figures would be very disheartening if they applied to anything but to a condition that is necessarily fatal, if untreated. It is true that we have reason to believe that the natural history of cancer of the prostate is, that it often progresses very slowly. I believe, however, that once the condition has begun to give marked symptoms, especially obstruction, that the patients are only exceptionally comfortable unless they submit to operation. The perineal removal of the growth can be done with little more risk to life than a cystostomy and a considerable proportion of these patients are able to go back to work for quite a period following operation; one worked for more than two years. Not only do we give a considerable degree of palliation but the careful operative removal of the growth will bring about in rare instances what is apparently a cure, clinically speaking. It seems probable that the use of radium as an adjunct to the operative removal of these growths will better the chance for cure, and also give longer periods of remission of symptoms.

It is my conclusion that in all instances where a malignant prostate is producing obstruction to urination it should be removed unless the patient's general condition is such as to absolutely preclude this. That in the cases in which patients complain of pain in the thighs or sacrum, the perineal removal of the growth will give temporary relief in some of the cases. That operation in carcinoma of the prostate should be carried out by the perineal route and that radium should be left in any bits of suspicious tissues that remain, or in the cavity from which the prostate tissue has been removed. That the removal of these growths may be carried out with relatively little risk when done by the perineal route; that there is little probability of a permanent fistula.

*Since the reading of this paper this patient has been reported as in good health.

The Massachusetts Medical Society

STATED MEETING OF THE COUNCIL.

OCTOBER 5, 1921.

A STATED meeting of the Council was held in John Ware Hall, Boston Medical Library, October 5, 1921, at twelve o'clock, noon. The President, Dr. John W. Bartol, was in the chair and the following 114 councilors present:

BARNSTABLE,
E. F. Curry.

BRISTOL NORTH,
Sumner Coolidge.

BRISTOL SOUTH,
E. F. Cody.
W. A. Dolan.

ESSEX NORTH,
F. W. Snow.
R. V. Baketel.
J. F. Burnham.
T. R. Healy.
G. E. Kurth.
J. J. O'Sullivan.
F. B. Pierce.
F. E. Sweetsir.
R. L. Toppan.

ESSEX SOUTH,
P. P. Johnson.
S. P. F. Cook.
J. F. Donaldson.
W. T. Hopkins.
J. F. Jordan.
G. M. Kline.
E. S. O'Keefe.
W. G. Phippen.
A. N. Sargent.

FRANKLIN,
H. G. Stetson.

HAMPDEN,
G. L. Gabler.

HAMPSHIRE,
A. J. Bonneville.

MIDDLESEX EAST
L. M. Crosby.
E. D. Richmond.

MIDDLESEX NORTH,
A. J. Halpin.
W. B. Jackson.
J. H. Lambert.
G. A. Leahey.

MIDDLESEX SOUTH,
E. H. Bigelow.
E. W. Barron.
C. O. Chase.
F. C. Curtis.
D. C. Dow.
W. E. Fernald.
G. W. Gay.
F. J. Goodridge.
F. R. Jouett.
H. J. Keaney.
C. E. Mongan.
C. F. Painter.
H. R. Rowen.
W. D. Ruston.
L. F. Sise.
C. H. Staples.
E. H. Stevens.
A. K. Stone.
F. R. Stubbs.
G. L. West.
W. S. Whittemore.
Alfred Worcester.

NORFOLK,
C. E. Allard.

NORFOLK (*continued*).
W. B. Batchelder.
E. H. Baxter
D. N. Blakely.
E. H. Brigham.
A. N. Broughton.
W. L. Burrage.
J. A. Ceconi.
W. A. Griffin.
F. C. Jillson.
G. W. Kaan.
Bradford Kent.
M. V. Pierce.
H. H. Powers.
Victor Safford.
Augusta Williams.

NORFOLK SOUTH,
C. S. Adams.
O. H. Howe.
G. M. Sheahan.

PLYMOUTH,
Gilman Osgood.
F. G. Wheatley.

SUFFOLK,
F. B. Lund.
J. L. Ames.
S. H. Ayer.
J. W. Bartol.
Robert Bonney.
V. Y. Bowditch.
F. J. Cotton.
L. J. Cummins.
Lincoln Davis.
J. E. Goldthwait.
G. S. Hill.
W. C. Howe.
J. C. Hubbard.
E. A. Locke.
F. T. Lord.
Donald Macomber.
A. H. Miller.
W. H. Robey, Jr.
Stephen Rushmore.
C. M. Smith.
J. S. Stone.
E. W. Taylor.
F. H. Williams.

WORCESTER,
J. J. Goodwin.
W. P. Bowers.
W. J. Delahanty.
G. A. Dix.
M. F. Fallon.
Homer Gage.
R. W. Greene.
David Harrower.
E. L. Hunt.
A. G. Hurd.
C. B. Stevens.
G. O. Ward.
S. B. Woodward.

WORCESTER NORTH,
W. E. Currier.
J. G. Henry.
H. R. Nye.
A. H. Quessy.

The Secretary read the minutes of the last meeting and as no errors or corrections were noted the record was accepted by vote. The President made the following remarks:

This being the first meeting at which I have had the honor of presiding, I shall bespeak your indulgence and coöperation through my inexperience in such matters. The program today is a full one and I promise not to trespass more than a few minutes

with opening remarks. The duties of the President are set forth with definiteness by the by-laws, and those by-laws say that the President shall keep in touch with the Districts as far as possible, making it his duty to do so. I will say that far from being a duty it is a great pleasure. It has been my good fortune to have been in actual touch with four of the District Societies, and the cordial hospitality with which they have greeted my presence has been a gratifying thing as indicating their attitude toward the Society in its larger aspects. I am looking forward at this moment with unmitigated pleasure to the first of the joint meetings which have already been defined in the reading of the minutes of our last meeting. Berkshire, Franklin, Hampshire and Hampden will meet in Springfield on Friday of this week; and I feel sure that the program brought to pass by Dr. Worcester will work to the very material advantage of the Society eventually. As you have already heard, the object of these meetings is to draw the society at large into a more close cohesion as a body politic, if we may use that expression, meaning anything rather than a political body; but I think in Dr. Worcester's words that the assumption is that matters have been at loose ends. After these meetings these isn't going to be any excuse for the members to claim lack of responsibility. There are 3,900 members approximately in the Society. That represents roughly two-thirds of the medical profession of the State. Is it conceivable that if 3,900 of us come together and are united on measures which are for the welfare of the population, that the legislature is going to refuse to give us such measures? I say not. That, however, brings us face to face with another of the duties of the President, and that is a stern duty far removed from pleasure and that is the duty of being *ex officio* chairman of the Standing Committee on State and National Legislation. Now I apprehend that that committee which has done able, efficient and hard work in the past is going to continue to do that sort of work, and I understand and feel sure that when we speak of a committee on State and National Legislation, we are not speaking of a lobbying committee but we are speaking of a committee that has to do a great deal of hard work, that has to be on the watch to give the alarm and that has to be the agent to initiate helpful and appropriate legislation looking to the public welfare. Now it is hardly conceivable that that committee can work alone. Consequently as in the past, so in the future it is going to issue cries for help, and those cries for help are going to be answered more in the future we hope than they have been in the past, not that they have been neglected in the past, but just as the past officers of the Society who have had to do with these matters have found, at the last moment it is almost too late to get the machinery going—the members don't understand exactly how they can help. Now if the joint meetings can bear fruit, we are going to know what the different members are asked to do and we will feel sure that they are going to do it. I am convinced that there is no question about that.

A sterling member of the Council was taken by sudden death on July 13. Dr. W. J. Gallivan throughout all his professional life had given an example of unstinted devotion to the public service. He was successively a member of the School Committee of the City of Boston and at one time its chairman. He became afterwards a member of the City Board of Health and was very influential in advancing matters of child hygiene the hygiene of the schools and the hygiene of the school children. He served as chairman of that body for a certain length of time after its organization. He afterwards became through the appointment of the State's executive a member of the Health Council of the new State Department of Health and he continued with that body until he resigned in order to take under that the position of chief of the Tuberculosis Department and director of the sanatorium. Alert, genial, progressive and sane, the State and the community share a mutual loss in his decease.

After consultation with the Secretary the Chair has decided to ask a favor of certain members of the Council. It has proved difficult in the past for the stenographer or the Secretary or the presiding officer to always make note of the individual speakers. The membership of the Council is large and changing frequently. It is difficult often to recognize the person who for the moment has the floor. We know those whom we are in the habit of seeing: those whom we have not seen for some time, even if we know them, are often difficult to name. Therefore the Chair will request that members speaking from the floor, as is the custom in other deliberative assemblies, state their names and the districts from which they come for the information of the Secretary and stenographer. That will facilitate very much in the effort to make our deliberations accurate, and it will help the Secretary who has a great many things to engage his attention, as it is.

The names of the Nominating Committee were called by districts by the Secretary, and those present retired to agree on a name for orator for the annual meeting in 1922, the orator elected last May not being able to serve.

The following answered to their names:

BRISTOL SOUTH,
E. F. Cody.

ESSEX NORTH,
T. R. Healy.

ESSEX SOUTH,
W. G. Phippen.

FRANKLIN,
H. G. Stetson.

MIDDLESEX SOUTH,
E. H. Stevens.

NORFOLK,
A. N. Broughton.

NORFOLK SOUTH,
G. M. Sheahan.

PLYMOUTH,
F. G. Wheatley.

SUFFOLK,
W. C. Howe.

WORCESTER,
David Harrower.

WORCESTER NORTH,
W. E. Currier.

Dr. Donald Macomber, Chairman, reported as follows for the Committee of Arrangements:

Your Committee has given the matter of the program for next June careful consideration and make the following unanimous recommendations: First, that the scientific and clinic program be much as it has been in past years. This has seemed on the whole to be satisfactory, and we see no reason to make any change. Second, instead of having, as last year, the dinner in the early afternoon, we will have the dinner, as has usually been the custom, at night; and we also recommend that the place for the meetings and the dinner be the Copley-Plaza Hotel. We felt that most members of the Society had been better satisfied with that hotel than with any other meeting place in recent years. The matter of finances for the meeting and the dinner may be summarized briefly as follows: The Copley-Plaza requires a minimum guarantee that 500 be present or be paid for at the dinner. The lowest price which they will quote us for a dinner in the ball-room is $3.00 a plate. That therefore makes the minimum guarantee to the Copley-Plaza $1,500. If there are more attending, it naturally increases the cost in proportion. Your Committee proposes that this expense be met by charging members attending the dinner $1.00 and having the Society take care of the remainder of the $3.00; that is, the Society pay $2.00 for each member attending. We also will have the usual incidental expenses. There will be no change in those so far as we can estimate at this time; they will be just the same as usual. We need not at this time consider the actual details of the meeting, but if the Council takes some action on the question of financial guarantee, the Committee will be able to go ahead with the arrangements and be

able to report to the Council in February on any actual details which the Council wishes to know.

It was moved by Dr. F. H. Williams that the report be accepted and its recommendations adopted, and the motion was seconded. An amendment to the effect that the annual dinner be given in the middle of the day rather than in the evening, was proposed by Dr. W. B. Jackson of Middlesex North and favored by Dr. Sweetsir of Essex North and by Dr. J. H. Lambert of Middlesex North. It was opposed by Dr. S. B. Woodward of Worcester, Dr. F. B. Lund of Suffolk and by Dr. Macomber. On being put to a vote a show of hands was asked for, the tellers, Dr. Robie, Dr. Davis and Dr. Ruston reporting that there were 24 in favor of the amendment and 50 opposed, therefore the amendment was lost. Dr. Williams' motion was then adopted by a unanimous vote.

Dr. Macomber spoke as follows concerning an exhibit at the annual meeting:

Mr. President, it has come to my attention as chairman of the Committee of Arrangements that other medical societies at their meetings, notably at the last meeting of the Medical Society of the State of New York, that they have had under their auspices a public health exhibit. This was also combined with a scientific exhibit of instruments and books and so forth, as I believe it was formerly the custom of this Society to have. This matter I have at least partially investigated and have looked up statistics and so forth and reports of the success of the meeting of last year at Brooklyn. Taken on the whole, it seems a remarkable opportunity for the Society to get before the public various ideas and matters of which they approve. It naturally is a rather expensive proposition to start such an exhibit, but the company which promoted this exhibit in Brooklyn last May, has gotten in touch with me and has submitted facts and figures on that meeting which make it evident that the Society would be under no financial obligation—would not have to pay out any money for the actual promotion of this meeting or exhibit but merely have to stand sponsor for it. I bring this to the attention of the Council for their consideration. We have not had time to investigate it thoroughly and get actual terms, but as I say, from the facts submitted to me, the Society would be under no financial obligations so far as I can see, and practically the whole responsibility for getting exhibits would be undertaken by this company. The question of the ethical standing of the exhibitors and advertisers would naturally come up, but the company assures me that all such questions would be left entirely in our hands. I merely bring this to your attention in case any action is to be taken by the Committee of Arrangements.

Dr. Dolan of Bristol South thought that the holding of an exhibit could be left to the committee as at present constituted; Dr. Lund, that the Society ought to be careful that the company arranging the exhibit was of the right sort ethically, or the commercial character would predominate, citing his experiences with the meeting of the American Medical Association last June; Dr. Sumner Coolidge of Bristol North, thought that the Public Health Committee of the Massachusetts Medical Society could be trusted to arrange a health exhibit without any expense to the Society. Dr. Edward Reynolds of Suffolk, spoke as follows:

Mr. President, this strikes me as a very important question and one with diverse aspects. I have happened to have had some little experience with these exhibits and I have seen good and bad features. I must confess that when I was first asked to take part in one of these exhibits at New Orleans by the A. M. A., I was much prejudiced against it. Having occasion to attend it, to go to it frequently, I became convinced that it exerted an influence and a desirable educational influence on many members of the profession and especially on those who most need educational influences, a matter which can hardly be appreciated by metropolitan physicians. It has become an outstanding and important feature of most of the more important medical societies. We want to be consulted, but we want to be progressive. I do not think that we should be too old fashioned not to move with the times. I think that such an exhibit should avoid what has been done too frequently—personal exhibits of doctors of their work. I think that it should avoid the exploitation of commercial remedies. I think that it is possible to arrange exhibits under the auspices of the various bodies who are devoting themselves to public work that should be of the greatest possible educational value. In connection with the American Society for the control of Cancer I have taken part since the first meeting, to which I shall refer, in a considerable number of these exhibits. I have learned to regard it as one of the greatest educational means of reaching both the public and the profession. I feel sure that we should be interested to prepare an exhibit if this Society has such an exhibition. I do think with Dr. Lund that it is important to guard ourselves against getting into the hands of commercial promoters, but I perhaps differ a little from him in that I think that the way to avoid that is to appoint a representative committee from this Society with power. We can easily appoint a committee which we can trust absolutely, and a small committee with power will deal much more judiciously with that danger than can be done in any other way; and I move you, sir, that the President and Secretary of the Society and the chairman of the Finance Committee be requested to confer with the Committee of Arrangements and that the joint committee so constituted be given power to make any arrangements in this matter for this end which they deem desirable, and furthermore that in the event of their deciding to have such an exhibition, the President be authorized to appoint additional members of the Committee of Arrangements for the care of the labor which such an addition to their work will entail, provided such additional members are judged to be necessary.

Dr. Reynolds' motion was discussed by Dr. Dolan and after being seconded, was put to a vote and passed.

Dr. E. W. Taylor, Chairman of the Committee on Publications and Scientific Papers, stated that in accordance with the by-laws, his committee had chosen Dr. Elliott P. Joslin of Boston to deliver the Shattuck Lecture, June 13, 1922, and that Dr. Joslin had accepted.

Dr. S. B. Woodward presented the report of the Committee on Membership and Finance as to membership. It was accepted and its recommendations adopted.

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE AS TO MEMBERSHIP.

The Committee on Membership and Finance make the following recommendations as to membership:

1. That the following named Fellows be allowed to retire under the provisions of Chapter I, Section 5, of the by-laws.

Mason, Atherton Perry, of Fitchburg.

2. That the following named fifteen Fellows be allowed to resign under the provisions of Chapter I, Section 7, of the by-laws.

Bowles, George Hall, of Plymouth, New Hampshire, (as of Jan. 1, 1921).
Brown, Henry Seabury, of Detroit, Michigan (5400 Grand River Avenue), as of Jan. 1, 1921).
Finlayson, Alan Daniel, of Cleveland, Ohio (2677 East 128 Street,) with remission of dues for 1920, (as of Jan. 1, 1921).
Greene, Edward Chace, of Camp Dix, New Jersey, Station Hospital, (as of Jan. 1, 1921).
Howard, Harvey James, of Peking, China, Union Medical College, (as of Jan. 1, 1921).
Lane, Clayton Rogers, of Santa Anna, California, With remission of dues for 1920, (as of Jan. 1, 1921).
Lena, Hugh Francis, of New London, Connecticut (154 Broad Street), (as of Jan. 1, 1921).
McCann, Gertrude Fisher, of New York City, New York (1273 Lexington Avenue), (as of Jan. 1, 1921).
Nesmith, Francis Marion, of Evansville, Indiana, Woodmere, (as of Jan. 1, 1921).
Rogers, John Andrews, of Carlisle, Pennsylvania, (as of Jan. 1, 1921).
Strahlman, Louis, of San Diego, California, (as of Jan. 1, 1921).
Swift, Henry Marshall, of Portland, Maine (30 Deering Street), (as of Jan. 1, 1921).
Tenney, William Northend, of Boston (294 Washington Street), (as of Jan. 1, 1921).
Tibbetts, Guy Daniel, of Antrim, New Hampshire, (as of Jan. 1, 1921).
Vickery, Eugene Augustus, of Boston (375 Commonwealth Avenue), (as of Jan. 1, 1921).

3. That the following named eleven Fellows be deprived of the privileges of Fellowship, under the provisions of Chapter I, Section 8, of the by-laws:

Ascher, Joseph, of Boston, (344 Hanover Street).
Boehm, Julius Benjamin, of Brooklyn, New York, (Greenpoint Hospital).
Bowen, Alfred Preston, of Lynn, Massachusetts (17 Fayette Street).
Choate, Horace Henry, of Gloucester, Massachusetts (54 Middle Street).
Witchcock, John Sawyer, of Proffit, Virginia.
McLeod, John Scott, of Long Beach, California.
Rafferty, Thomas Bernard, of Lynn, Massachusetts (120 South Common Street).
Schwartz, George Harvey, of East Boston, Massachusetts (43 Princeton Street).
Sisson, Mitchell, of East Boston, Massachusetts (199 Chelsea Street).
Washburn, Elliot, of Providence, Rhode Island (100 Washington Street).
Woodbury, Herbert Elwell, of Indianapolis, Indiana (1321 North Meridian Street).

4. That the following named five Fellows be allowed to change their membership from one district society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the by-laws:

Gafney, Harry Dabol, of Ware—from Hampshire to Hampden.
Jackson, Delbert Linscott, from Norfolk to Suffolk.
Pearson, Maurice Wellesley, of Ware—from Hampshire to Hampden.
Ryan, Dennis Matthew, of Ware—from Hampshire to Hampden.
Wheatley, Frank Edward, from Norfolk South to Suffolk.

For the Committee on Membership and Finance,
SAMUEL B. WOODWARD, *Chairman*.

Dr. S. B. Woodward read the report of the Committee on Membership and Finance on the question of mileage (see Appendix No. 1) and also the finding of this committee on the question of the appropriation for the Committee on Maternity and Infant Welfare, referred to them last May (see Appendix No. 1, at end). Both reports were adopted.

Petitions from the following were read by the Secretary and committees to consider them were nominated by the Chair and appointed by the Council:

For F. H. Parker—A. Worcester, E. F. Cody, E. G. Brackett.

For Henry Harrison—J. W. Cummin, G. F. Keenan, E. L. Oliver.

For H. L. Flynn—J. P. Broderick, A. N. Broughton, F. C. Jillson.

For D. W. Heffernan—D. L. Healy, J. E. Dodd, James Glass.

Dr. Edward Reynolds reported for the Committee on Cancer in this language, concluding with a resolution:

Your Committee has to report that since the last report it has maintained relations with the State Committee of the American Society for the Control of Cancer and that it is at present actively engaged in a campaign for the education of the public especially, and for the interests of the medical profession in what is known as "Cancer Week," which is the week beginning October 30. This is nation wide and is being taken up very actively all over the Union. To some of us these weeks seem strange, but experience has shown that all over this country they are the most effective means of awakening general interest, and it has been surprising to see during our work of the last cancer week the degree of enthusiasm in Massachusetts. Cancer, as you all know, kills more adults than any other known disease, and it is certainly true that a large proportion of all those deaths could be saved if the public could be educated to attention to the precancerous stages, and it has become in the eight years in which I have been interested in the affairs of the American Society for the Control of Cancer—it has become sadly evident that a large proportion of the medical profession need the same education. It has become evident, too, that it is not confined to the dwellers in distant villages but that men who act as consultants are too often ignorant of the modern developments in the surgical treatment of cancer. On all counts it seems to your Committee that this present campaign is one which should be favored and urged forward, and your Committee wishes to offer a resolution that the President of this Society be requested to open communication with the presidents of the district societies informing them that the Council approves this campaign and hopes that the district societies will lend it every aid in their power.

The resolution being put to a vote was adopted.

The President nominated and the Council appointed the following delegates to the annual meeting of the Vermont State Medical Society at St. Albans, October 13 and 14, 1921: Dr. P. P. Johnson, Beverly, and Dr. W. G. Phippen, Salem; he also nominated and the Council appointed this Auditing Committee: Dr. C. M. Green and Dr. R. G. Wadsworth. Vacancies in the Committee of Arrangements

were filled by these appointments: J. C. Rock and L. S. McKittrick.

The Nominating Committee brought in the name of Dr. Benjamin Kendall Emerson of Worcester for orator at the annual meeting, June 14, 1922. On motion by Dr. Woodward, the Secretary was directed by a unanimous vote to deposit one ballot for Dr. Emerson. After it had been so deposited, the Chair announced that Dr. Emerson had been duly elected orator.

Dr. W. E. Fernald of Middlesex South, read his report as delegate to the Second International Eugenics Congress in New York last September and it was received with applause (see Appendix 2), and adopted.

Dr. H. G. Stetson of Franklin read a report for the Society's delegation to the House of Delegates of the American Medical Association last June and it was adopted and placed on file (see Appendix No. 3).

The report of the committee appointed at the last meeting to consider a suitable memorial to Dr. Samuel Fuller, Massachusetts' first physician, was read by the Chairman, Dr. R. M. Green (see Appendix No. 4). On motion by Dr. Ward, one of the committee, the report was referred to the Committee on Membership and Finance, by vote.

Dr. W. P. Bowers, chairman of the committee appointed at the annual meeting, June 1, 1921, to arrange a group meeting of the district medical societies, read a report for that committee (see Appendix No. 5). It was accepted and placed on file.

Dr. Bowers presented the report of the Committee on Maternity and Infant Welfare, appointed by the Council last February. Both the main report, unanimously adopted by the committee, and the "addenda," signed by three members of the committee, were accepted and ordered printed (see appendix No. 6).

Dr. Bowers brought up the subject of indemnity insurance against suits for malpractice with a motion that the Council proceed to a discussion of indemnity insurance. The motion having been carried, he said:

This matter has been brought to the attention of the profession through the columns of the BOSTON MEDICAL AND SURGICAL JOURNAL by reason of the fact that the insurance companies which provided a certain amount of indemnity to physicians for malpractice or alleged malpractice suits had threatened to raise the rates very largely. The former rates were $14.00 a year for a $5,000. indemnity policy. And then a threat was made to jump that rate up to $40.00 a year; and so the JOURNAL after an investigation published a statement to the effect that the office of the JOURNAL would be placed at the disposal of the members of the Society if the members felt disposed to develop a mutual insurance company, and the plan as outlined by the JOURNAL involved a very simple process in that the members could form a company, could pay in their assessments to the office of the JOURNAL, have the money deposited in a bank or invested in any way which an executive committee might see fit, and in that way provide for the administration of this type of business without any overhead expense; that is, there would be no expense for officials and no expense for rent; the only expense being for the stationery and clerk and the simple matters of ordinary writing expenses and postage and so forth. It was found that the law provides that no organization can operate as an insurance company of this type without first paying in an amount equal to $50,000. That is the great objection to this particular plan. There is practically no other serious objection to this plan. Of the objections raised, the principal one is that physicians are incompetent to handle financial affairs, but that has hardly any basis in fact because it is evident that certain physicians have some training along this line. The development of this plan resulted in the activity of a gentleman in Boston who is known to many of you, a Mr. George H. Crosbie, who is a representative of a number of insurance companies, and I want to say, before outlining in advance what Mr. Crosbie had to present, that he is a fair minded man and a man interested in the medical profession, and he showed that he is interested in the problem by securing from an insurance company a rate less than what was called for before; that is, he is able to carry out a group insurance on an assessment of $21.00 a year on a $5,000. indemnity policy. His argument is that insurance under this plan would relieve the Massachusetts Medical Society of any system of investigation of suits and in that way it would be of distinct benefit to the Society if the members were disposed to take out that form of insurance. The only argument against that is that we have no assurance of a continuance of those low rates. Massachusttts isn't regarded as a favorable field for indemnity insurance; that is, it hasn't as good standing with some of the insurance companies as some of the other states,—New York, for example. So that while Mr. Crosbie feels that this rate will not be increased and might be decreased, still that is one of the problems of business that would have to be taken into the consideration of this matter.

The other problem, mutual insurance, would be under the control of those who went into it and would be as inexpensively managed as anything of that kind could possibly be. Now the Journal has no disposition to advocate one plan over the other. The Journal simply places itself at the disposal of the members of the Society, and in using the term "Society," it is necessary to explain that the Society cannot go into any such business whatever, as it has no provision in its charter. So whatever is done, must be done by members of the Society acting for themselves and not by the Society as a whole. Of course, if the members of the Society care to go into a mutual insurance plan, the Society would still be under obligation to defend its members just as it has been in the past, under its "malpractice act."

To reiterate—under the group plan, in charge of a special insurance company, the Society would be relieved of all the trouble of management because that would be done by the legal machinery of the insurance company. I think that is a good plan.

Dr. J. S. Stone, Suffolk, said: I think that the Society owes Dr. Bowers a great deal for having brought up this matter of insurance. It has been in the interest of Mr. Crosbie to act with the insurance companies and bring them down to earth. There is one important thing which Mr. Crosbie has brought out in discussion. The Massachusetts Medical Society has been able to carry on the defense insurance of its members at less expense because a great number of men have carried commercial insurance and the outside insurance has relieved the Massachusetts Medical Society from defending a great number of suits. If the Society or if members of the Society drop outside insurance and depend on

the defense insurance of the Society and also organize themselves into an association to pay indemnity after court verdicts are rendered, there is a strong probability that there will be a great increase in the expenses put on the Society. I think Dr. Bowers' plan is admirable, but I think if it is adopted, the expense put upon the Society will be very greatly increased.

There are so many details to be considered in settling this matter of insurance that I would move that the Chair appoint a committee of five to consider this entire subject and to report at some future meeting of the Council. It seems to me that it might be well for the Committee before reporting, to meet Mr. Crosbie and not only to meet him, an agent, but to meet some of the officers of the insurance companies with which Mr. Crosbie proposes to deal. Of course, we all recognize that the insurance companies are not in business for their health, and I think we all recognize that they are entitled to a fair money return; but I do think we want some reasonable assurance from the officers as well as from agents that the companies do not propose to raise rates unreasonably, that they do not propose another increase of 300 percent such as took place during the present year.

Dr. J. H. Lambert, Middlesex North, said: I second Dr. Stone's motion, but it seems to me that when this committee is appointed and is instructed to confer with Mr. Crosbie and insurance companies which he represents, that it would be well to investigate other insurance companies which he does not represent—and that is not throwing any reflections on Mr. Crosbie and his companies—but there are insurance companies in the United States which are insuring physicians for reasonable sums of money that have grown up and have been in business for some time and their standing is good; so I think it would be fair to take in other companies.

Dr. G. W. Gay, Middlesex South, said: The object of this move is to take care of those men who want indemnity insurance at $21.00 a year instead of at $40.00 or $45.00. You will get your insurance for $21.00 according to the Crosbie plan. The suggestion of the last speaker is that this committee do not confine itself to the two plans—one, the mutual plan and the other the group plan in connection with the United States Fidelity and Guaranty Company of Baltimore, which is the one which Mr. Crosbie represents.

There are two points which have not been mentioned—one is that the only responsibility put on the Massachusetts Medical Society if we go into this group plan, is that we must assure the insurance company of 400 subscribers. It has been stated that there are over 2,000 who carry indemnity insurance. Whether that is true or not you know better than I. But it would seem that in a Society of 3,900 members there wouldn't be much risk of not securing 400 odd subscribers who would take out the indemnity insurance at $21.00 a year.

Another point has not been mentioned in relation to the mutual plan of insurance. I took the liberty to ask our counsel, Mr. E. P. Saltonstall, if there was any objection to the Massachusetts Medical Society paying indemnity insurance or paying for verdicts or settlements. He gave me the information which Dr. Bowers has given you, but he also gave me one other point which I think is important. He says: "Your articles of incorporation contain nothing which would seem to warrant your undertaking to pay verdicts or settlements in malpractice suits against its members and I should therefore assume that if you were going to undertake this work you would have to obtain an amendment to your charter."

Anyone who knows anything about the situation in this State has no desire to open up our charter on Beacon Hill. I think this committee is an important one, and I should like to have them report before the next meeting of this Society. If it could report in November, it would be very much desirable.

The Chair: Are there any other remarks? As I understand the motion, the consideration of the mutual plan would be included; that is, the committee would consider and weigh that as well as the group system. I take it Dr. Stone has adopted the further suggestion, namely that this committee make a thorough investigation of the insurance question and that they be not limited to any one company or to any one agent, that they report on indemnity insurance as it may be available for the Society.

Dr. S. Rushmore, Suffolk: I would like to make an amendment, and that is that the committee report at an adjourned meeting of this Council on a specific date. Whether that requires a special motion in addition to that motion I don't know, but an adjourned meeting in this hall on the second Wednesday of November, November 9, at 12 o'clock, noon.

The Chair: The Chair would be of the opinion that if Dr. Stone chose to incorporate that, there would be no need to put a separate motion.

Dr. J. S. Stone: I incorporate it.

The Chair: The Chair understands that a committee of five will be appointed by the Chair and given instructions to investigate the insurance question and that they will be expected to report back at an adjourned meeting of this Council and that adjournment will be to the second Wednesday of November. The motion is seconded. Is there anything to be said on this motion?

Put to vote; motion carried.

The Chair subsequently appointed the following committee:

W. P. BOWERS, *Chairman*.
E. H. STEVENS
P. E. TRUESDALE
E. A. BATES
A. P. MERRILL.

Dr. A. H. Quessy of Worcester North, presented a preamble and resolutions prepared by Dr. Atherton P. Mason of Fitchburg, a former councilor from Worcester North, protesting against legislation which he thought restricted the rights of physicians (see Appendix No. 7). Dr. Quessy spoke at length in explanation of the resolutions. He said: The question resolves itself into: Is alcohol or liquor of medicinal or therapeutic value, or is it not? If it is not, if alcohol has no medicinal or therapeutic value, then the Government should not give to practising physicians the right to prescribe liquors. The Government having given the right to so prescribe, alcohol must be regarded as of medicinal value. He thought the present situation put the physician, in the eyes of the public, in the place of the banished saloon; the remedy he thought to be governmental depots or bureaus for the distribution of alcoholic beverages.

On motion by Dr. Cody, the resolutions were referred to the Standing Committee on State and National Legislation, by vote.

Adjourned at 2.45 P.M., to meet on the second Wednesday in November, 1921, at twelve o'clock, noon, in John Ware Hall.

WALTER L. BURRAGE, *Secretary*.

APPENDIX TO PROCEEDINGS OF COUNCIL, OCTOBER 5, 1921.

APPENDIX 1.

Committee on Membership and Finance Report on Mileage.

The Committee on Membership and Finance was directed by vote of the Council May 31, 1921, to consider the question of paying mileage to members of the Committees of the Society and to make a recommendation to the Council "with a view to establishing a custom to be followed in the future."

In the early days of the Society members served for the joy of service, and it was not until 1839 that any Committee member seems to have been paid in any way for his work.

In that year the Council voted to pay two dollars a day to each member of a Committee made up of one appointed from each county to consider an alteration of the organization of the Society, this sum to be paid while the Committee was in session in addition to the "usual expense of travelling by stage or railroad to the place of meeting."

Ten years later, namely, in February, 1849, a special committee consisting of Augustus A. Gould, John Homans and Ebenezer Alden, made the following report on the subject of payment to members of the Society's Committees:

The Committee appointed to consider the subject of pecuniary remuneration for expenses incurred by committees in the discharge of their duties, would report:

They are unanimously of the opinion that to establish a rule by which committees would be authorized to expect pay for time or travelling expenses would be inexpedient, and would involve the Society in serious embarrassment. Some of the reasons which lead to this conclusion are as follows:

1. Unless other than the usual sources of revenue are available, the Society has not the means of doing it.

2. The indefinite nature of the demand is another objection. There is no standard by which to estimate travelling expenses. Now, if time is to be taken into the account, is there any method by which the real sacrifices of practitioners in different sections of the State could be satisfactorily ascertained or justly apportioned?

3. But above all, it has not been the custom in this or other Societies for kindred purposes. In Political, Religious, Literary and Benevolent Societies, no remuneration to committees is thought of, nor is it made excepting to those who devote themselves by contract to the especial duties of those associations for a stipulated portion of the time. The business of this Society has hitherto been transacted gratuitously except in a single instance, about 20 years since, involving much time and expense; and it is believed that it may be hereafter performed, with equal acceptance, by the leading men in the profession. The tax, it is true, is a serious one, but it is the legitimate penalty of office. No one enjoys an honor worth the having without paying dearly for it. On the other hand, he does receive from the possession of rank and office, a consideration in the mind, both of his associate and the public, which is of real value to him professionally.

Nor is the sacrifice in behalf of the Society, even when it involves long journeys, an unmitigated one. Few men of such standing in society and in the profession as those who are delegated on important affairs, have not other business, either professional or private, which they may render coincident with their labors for the Society.

These services, moreover, are allotted to successive series of men. Our elders and betters have performed them for us; and it is but just that we should in our turn bear a similar burden, soon to shift it off upon the shoulders of our juniors.

In view of these considerations and others which might be urged, the Committee are of opinion that no expectations of pecuniary remuneration for services connected with the legislation or the scientific labors of the Society should be held out, except in extraordinary cases, and when provided for at the time the committees are appointed. In such cases, a sum not exceeding that allowed to a Censor, with perhaps the addition of a certain rate of mileage, may be allowed to such as choose to accept of it.

Committees may also feel authorized to demand reimbursement for any sums expended for postage, stationery, printing, room rent and similar incidental expenses which they may have incurred in the prosecution of their commission.

All which is respectfully submitted,

Augustus A. Gould,
John Homans,
Ebenr Alden,
Committee.

Boston, February, 1849.

The Council accepted this report and until 1877 no further action was taken in the matter.

In that year, ninety-six years after the incorporation of the Society, it was voted that there shall be allowed to the Committee on Ethics and Discipline such mileage, not to exceed five cents a mile, and such incidental expenditures as are required for the proper discharge of its duties.

This Committee was a comparatively new committee, having been established six years before, namely, in 1871.

For a long time this Committee was apparently the only one the members of which received a mileage compensation, but of late years, particularly since the establishment of the budget system, it has become the custom more and more to allow to members of standing and special committees the actual expenses incurred in travel to and from the place of meeting, the matter being decided by the individual committees.

Some committees have never done this, notably the Committees on State and National Legislation and on Membership and Finance, which are incidentally the committees holding, perhaps, the largest number of meetings during the fiscal year. It is obvious that there should be uniformity in the matter, for members coming from a distance sacrifice much more in loss of time and opportunity than those living nearer to the place of meeting, and as the custom seems to meet with the approval of the majority of the standing committees, the Committee on Membership and Finance, albeit somewhat embarrassed by the fact that three of its five members, including the Chairman, would be affected by the change, and although they are tempted to simply state the facts, advocate uniformity and leave the decision of the matter to the Council, do, inasmuch as they have been directed to make a recommendation, recommend that mileage be paid to such members of standing and other committees as are willing to receive it, such mileage to be based on actual disbursement for travel to and from meetings.

The vote of the Council not having included the question of paying the expenses of delegates to conventions and to other societies, these matters were not considered by us.

Approval of Request for Appropriation for Committee on Maternity and Infant Welfare.

A request to your Committee by the Committee of Seven on Maternity and Infant Welfare for an appropriation of $150 to be taken from the contingent fund, is approved.

For the Committee on Membership and Finance,
Samuel B. Woodward, *Chairman.*

APPENDIX 2.

Report of Delegate to Second International Congress of Eugenics.

I have the honor to present the following report as the delegate from the Massachusetts Medical Society to the Second International Congress of Eugenics, held in New York City, September 22–28, 1921.

The first congress was held in London in 1912.

The meetings of the second congress were held in the American Museum of Natural History, New York City. This congress was held under the auspices of distinguished scientists from all over the world, including England, France, Italy, Norway, Sweden, Denmark, Argentina, Chile, Czecho-Slovakia, Mexico, Australia, the United States and other countries. There were elaborate special exhibits and studies in the fields of human and comparative heredity, eugenics in the family, and eugenics in the state, covering charts, maps, pictures, models and scientific apparatus.

In the opening address Major Leonard Darwin, S.D., defined the aim of the Congress as the study of methods of improvement of the racial qualities of future generations.

The papers and discussions of the Congress were presented in four sections.

In the first section, on Human and Comparative Heredity, were presented, on the one hand, the results of experiments and research in the domain of pure genetics in animals and plants, and on the other, the application of these studies to human heredity.

The application to man of the laws of heredity and the physiology of reproduction as worked out on some of the lower animals were presented in such papers as "A Summary of the Effects of Excessive Alcohol Treatment on Heredity and Development in Mammals," "Effects of Inbreeding on Guinea Pigs," etc.

The second section, on Eugenics and the Human Family, considered the factors which influence the human family and their control; the relation of fecundity of different strains and families and the question of social and legal control of such fecundity; also the differential mortality of the eugenically superior and inferior stocks and the influence upon such mortality of special factors, such as war and epidemic and endemic diseases. First in importance among the agencies for the improvement of the race in the marriage relation, with its antecedent mate selection. Such selection should be influenced not only by natural sentiment but by a knowledge of the significant family traits of the proposed consorts and of the method of inheritance of these traits. In this connection were brought forward the facts of improved and unimproved families and of the persistence, generation after generation, of the best as well as the worst characteristics. Such papers were presented in this section as "Intermarriage of Blood Relatives in Three Old New England Communities," "The Effect on the Germ Plasm of Isolation in a Mountain Section," "The Codification of Social Groups; Evidence from New England Families," etc.

The third section, Human Racial Differences, concerned itself with the topic of human racial differences, with the sharp distinction between racial characteristics and the unnatural associations often created by political and national boundaries. In this connection were considered the facts of the migration of races, the influence of racial characteristics on human history, the teachings of the past with bearings on the policies of the future. Certain prejudices directed towards existing races will be removed when allowance is made for the influence of their social and educational environment, and their fundamentally sound and strong racial characteristics are brought to light. On the other hand, limits to the development of certain races, and the inalterability through education and environment of the fundamental characteristics of certain stocks were considered. It was emphasized that the three main races of France,—the Mediterranean, the Alpine, and the Nordic,—had preserved their racial traits unchanged after thousands of years of similar environment and education. Finally, the advantages and disadvantages of the mingling of races, of unions which have proved fateful to social progress, were discussed. The results of research upon racial mixture in relation to human history, and the topics of racial differences in diseases and psychology, were also taken up, and the history of race migrations and their influence upon the fate of nations, especially modern immigration, were also set forth. Such papers were presented as, "Some Results of Race Mixture in Hawaii," "Intermarriage between Jews and Christians," "The Physical and Physiological Characteristics of Old Americans," etc.

The Fourth section, Eugenics and the State, presented the topics of eugenics in relation to the state, to society and to education, including studies on certain practical applications of eugenic research, and on the value of such findings to morals, to education, to history and to the various social problems and movements of the day. In this section were considered the bearing of genetical discoveries upon the question of human differences, and upon the desirability of adjusting the educational program of such differences. Here also were considered the importance of family history studies for the better understanding and treatment of various types of hospital cases and those requiring custodial care. The bearings of genetics on sociology, economics and the fate of nations were considered. Papers were presented on such topics as "Eugenics in Its Relation to the Tuberculosis Problem," "Eugenics as a Factor in the Prevention of Mental Disease," etc.

The papers and discussions of the Congress were almost without exception on a high plane, with no fads or freak panaceas for human welfare. The keynote of the meeting was the utilization of the results of scientific research for human betterment. There are two practical phases of eugenics:

1. Positive Eugenics, which aims to encourage the propagation of the superior types of the human family;

2. Negative Eugenics, which has for its aim the limitation of the progeny of the feeble-minded, the criminal, and the physically, morally and socially unfit.

Major Darwin, son of the author of "The Descent of Man," urged that sound, fit and superior people should, by a campaign of patriotism, be induced to raise larger families. He said that racial deterioration seemed evident among all highly civilized people because of the thinning out of the descendants of highly endowed stock, and the multiplication of those of inferior endowment. History taught, he said, that the great races of the past had all fallen from high estate because of the progressive elimination of their best types.

The papers presented at the Congress will soon be accessible in a single volume. The Proceedings of this Congress will constitute an absolutely up-to-date statement of the present knowledge of the laws of human heredity, and will be of great practical interest.

Walter E. Fernald, *Delegate.*

APPENDIX 3.

Report of the Delegation of the Massachusetts Medical Society to the House of Delegates of the American Medical Association at the Meeting of the Association, in Boston, June 6-10, 1921.

The Society was represented by the full quota of five delegates, namely: J. F. Burnham, E. F. Cody, C. E. Mongan and H. G. Stetson, of the regularly

appointed delegates, and Dr. W. H. Robey as alternate for Dr. F. B. Lund. Two members of the delegation received appointments upon reference committees: Dr. Burnham to the Reference Committee on Reports of Officers, and Dr. Stetson to the Reference Committee on Legislation and Public Relations.

The complete report of the work of the House of Delegates is already in the hands of the members of this Society who receive the *Journal of the American Medical Association*, and any detailed account is therefore unnecessary in this report. Your delegates would simply emphasize certain portions of the report as being, perhaps, of particular interest.

The Secretary's report shows that of the 145,608 physicians in the United States, 84,791 are members of the American Medical Association through membership in their State or County Societies. This is about 58 per cent. Of this membership, 48,318 are Fellows of the National Association, an increase since the last report of about 4,000.

The financial condition of the Association is found in the Auditor's report. This shows that the organization has a plant equipment of about $270,000, a reserve investment of nearly $300,000, and a surplus over its liabilities of nearly $500,000.

The expense of publication of the Journal of the Association amounted to $791,000, and this expense includes depreciation on property and equipment, while the income was $954,000, leaving a net income from this source of nearly $163,000. The Association expenses *per se* amounted to about $85,000, and miscellaneous expenses, such as depreciation on buildings, insurance, taxes, etc., to about $52,000.

As usual, the most interesting and the most valuable reports submitted by the various committees and councils, were The report of the Council on Health and Public Instruction, the chairman of which is Dr. Victor C. Vaughn of Michigan, and the report of the Council on Medical Education and Hospitals, which has for its Chairman Dr. A. D. Bevan of Chicago. These reports should be carefully read by all members of this Society in order that they may realize the great amount of work that is being carried on by the American Medical Association in an educational way. The report of Dr. Bevan is particularly interesting from its impartial, judicial discussion of some of the educational problems in the study of medicine in the present day. The Hospital situation, from an educational standpoint, is also gone into very completely.

In the regular routine business of the House, nothing brought out so much heated discussion as the disposition of the various resolutions submitted for endorsement by the House and relating to so-called State Medicine, Health Centres, Group Medicine, Diagnostic Clinics, Health Insurance, etc., that are controlled in whole or in part by the state or National Government. If the House of Delegates can be taken as representative of the medical profession of the country, it will be some time before the advocates of the above-mentioned groups receive any very cordial support from the great body of physicians.

The total voting membership of the House of Delegates is limited by the Constitution to 150, and in order that this number shall not be exceeded, a reapportionment is called for every third year. Such reapportionment was made this year on the basis of one delegate for each 850 members or fraction thereof in each constituent association. On this basis, the Massachusetts Medical Society is entitled to five delegates, as in the past.

At the final session of the House on Thursday afternoon, the following resolution was offered and unanimously carried:

Resolved: That the thanks of the American Medical Association be extended to the Massachusetts Medical Society, the organized profession of Boston, to the Governor of the State, to the Mayor of Boston, and to the Citizens of Boston, especially its ladies, for the cordial hospitality extended during this annual session; and also that our thanks be extended to the daily press of the City for the full and fair reports of its deliberations.

If one may judge from opinions expressed by a number of delegates from various parts of the country, the meeting in Boston in 1921 may be regarded as more than ordinarily successful, enjoyable and profitable.

For the Delegation, H. G. STETSON,

APPENDIX 4.

REPORT OF COMMITTEE APPOINTED TO CONSIDER SOME SUITABLE MEMORIAL TO DR. SAMUEL FULLER.

After some preliminary correspondence to ascertain the opinions of individual members, a meeting of the Committee was held at Plymouth on August 8, 1921. Dr. Hill very hospitably entertained the Committee at luncheon at the Old Colony Club.

Three principal suggestions were brought before the Committee for consideration:

1. That a tablet be erected to mark the site of Dr. Samuel Fuller's house in Kingston. This would cost about $250.

2. That a bronze door in memory of Dr. Fuller be placed in the First Church at Plymouth, of which he was a deacon. This would cost about $2500.

3. That a sum of money, to be known as the Samuel Fuller Memorial Fund, be raised, and applied to the establishment of a bed or ward at the Plymouth Hospital. This fund should be in the nature of a permanent memorial. It might be augmented in future by further subscription to perhaps $25,000. A suitable tablet to commemorate this gift should be placed in the Hospital.

Upon discussion, it was the opinion of the Committee that Plans 1 and 2, though both excellent as memorials to Dr. Fuller, were not as appropriate for a memorial by physicians to a physician, as a gift to a hospital whose benefit might be perpetual to those in need of medical care. It should be easily possible to raise at least enough money ($5000) to endow a bed. The Plymouth Hospital is greatly in need of a maternity ward of ten beds. If a sufficient sum could be raised, it would undoubtedly be possible to name such a ward The Samuel Fuller Maternity Ward, and to have Dr. Fuller's service to medicine as the Pilgrim Physician suitably commemorated therein by a tablet. It was further the opinion of the Committee that subscriptions of from $1.00 to $5.00 for the Samuel Fuller Memorial Fund should not be limited to members of the Massachusetts Medical Society, but that invitations to subscribe to this fund should be extended to medical societies and individual physicians throughout New England and the United States. Subscriptions from interested private individuals, not physicians, would also be acceptable. A suitable certificate of subscription should be issued to each contributor.

The Committee therefore recommends:

1. That the Massachusetts Medical Society undertake to raise a fund to be known as the Samuel Fuller Memorial Fund, for the purpose of establishing at the Plymouth Hospital a permanent memorial to Dr. Samuel Fuller, the Pilgrim Physician.

2. That subscriptions of from $1.00 to $5.00 to this fund be invited from members of the Massachusetts Medical Society, and from members of other medical societies and from the individual physicians throughout New England and the United States.

3. That subscriptions from interested private individuals, not physicians, be also invited.

4. That a suitable certificate of subscription be issued to each contributor.

5. That the fund, when raised, be applied, in accordance with its size, to the establishment of a

free bed or maternity ward at the Plymouth Hospital, to be named in memory of Dr. Fuller.

6. That a suitable, but inexpensive, tablet be also placed at the Plymouth Hospital commemorative of Dr. Fuller and of this gift in his honor.

ROBERT M. GREEN, *Chairman.*
C. H. BANGS.
G. O. WARD.
MYLES STANDISH.
E. D. HILL.

APPENDIX 5.

REPORT OF COMMITTEE TO ARRANGE GROUP MEETINGS OF THE DISTRICT SOCIETIES.

The Committee appointed at the Annual Meeting, June 1, last, to try to arrange joint meetings of the District Societies for the purpose of enabling the President to confer with the members of the Society on matters relating to legislation and the affairs of the Society present the following report:

Letters were sent to the Presidents and Secretaries of the District Societies presenting a plan for meetings in six groups, *viz.:*

Group I. — Berkshire, Hampden, Hampshire, Franklin.

Group II. — Worcester, Worcester North.

Group III. — Middlesex South, Norfolk, Norfolk South.

Group IV. — Middlesex North, Middlesex East, Essex North, Essex South.

Group V.—Suffolk.

Group VI. — Plymouth, Barnstable, Bristol South, Bristol North.

with the suggestion that Group I hold its joint meeting the first week of October, Group II the second week in October, Group III the third week in October, Group IV the first week in November, Group V the fourth week in October, and Group VI the second week in November.

Group I has arranged to meet in Springfield at the Kimball Hotel, on the seventh of October. Group II will meet at Clark University, Worcester, October 12 at 8.15 P.M. Group III will meet November 29 at the Tufts College Medical School. Group IV has been invited by Dr. Pettingill to meet at the Tuberculosis Sanatorium in Middleton November 2. Group V will meet October 26 at the Boston Medical Library. Group VI will probably be invited by Dr. Sumner Coolidge to meet at the Lakeville Sanatorium the second week in November.

It is probable that Plymouth and Bristol North Districts in Group VI will coöperate in this plan, but Bristol South is reported as unfavorable; however, such members as might care to attend could do so, and therefore, the committee recommends that the meeting embracing the Plymouth, Barnstable, Bristol South and Bristol North, meet as tentatively arranged by Dr. Coolidge.

Suggestions have been made that some interesting scientific papers be presented at each meeting in order to attract as many of the Fellows as possible so that the President and his committees may have a representative audience.

It will be advantageous to have a reporter appointed for each meeting so that any action taken may be published under authority.

WALTER P. BOWERS, *Chairman.*
F. E. JONES.
A. P. MERRILL.

APPENDIX 6.

REPORT OF COMMITTEE ON MATERNITY AND INFANT WELFARE.

For several years measures for Maternity Aid have been under consideration by the Legislature of Massachusetts. Some measures proposed financial aid; others attempted to deal with the problem as a matter of public health. The Vital Statistics of Massachusetts show a steady increase in the death rate in the puerperal state as well as in the death rate from puerperal septicaemia since 1901, at which time the International Classification of diseases was adopted in Massachusetts as the basis for reporting deaths.

In 1920 the Special Commission appointed by the Governor investigated the subject and presented a unanimous report, expressing the opinion that many deaths of mothers were preventable, and that mortality would be lessened if women placed themselves more promptly and more generally under prenatal care.

The medical profession as represented by the Joint Committee on Legislation of the Massachusetts Medical Society and Massachusetts Homeopathic Medical Society, and the Council of the Massachusetts Medical Society and various local societies have in general opposed any legislation for Maternity Aid. This subject has been referred to the next session of the Legislature which convenes next January.

In February, 1921, the Council of the Massachusetts Medical Society appointed a Special Committee of Seven to study any measures for Maternity and Infant Welfare. This Committee added to its membership two representatives of the Massachusetts Homeopathic Society, and on May 31st presented a unanimous report to the Council, which has been published in full in the BOSTON MEDICAL AND SURGICAL JOURNAL (issue of June 23, 1921).

The Committee pointed out that the published statistics gave a wrong impression, because many so-called maternal deaths were not deaths at the time of confinement, but were deaths included under the term puerperal state, and that therefore inferences drawn from the statistics were misleading. We believe further that comparative statistics such as have been published in the professional and lay press are not reliable because of changes and improvements in classification.

As constructive suggestions, the Committee recommended the development of obstetric wards, obstetric services, and prenatal clinics in connection with existing hospitals and institutions, so far as local conditions permitted. Adequate hospital records and greater accuracy in the filing of death certificates were also urged, as well as careful supervision of the licensing of lying-in hospitals.

The Committee was continued and was authorized to coöperate with any other medical body interested in the same subjects. It is confronted by very difficult problems. The whole truth regarding mortality statistics and suggestions, if any are found necessary for the betterment of conditions, can come only from a detailed study of all deaths occurring in the puerperal state as they are reported.

It is proposed, therefore, that the following letter be sent to every physician in the state reporting a maternal death. It will be sent entirely impersonally and in no spirit of criticism. The replies will be confidential so far as names or any means of identification are concerned.

The Committee asks the coöperation of the medical profession, and hopes to be able to point out ways in which the task of the physician, in so far as it relates to obstetric practice, may be made easier and in which mortality and morbidity of mothers and infants may be lessened.

W. P. BOWERS, *Chairman.*
J. S. STONE.
C. E. MONGAN.
RICHARD DUTTON.
THOMAS ALMY.
B. W. PADDOCK.
R. L. DENORMANDIE.
E. P. RUGGLES.
O. R. CHADWELL.

LETTER TO BE SENT TO EVERY PHYSICIAN IN THE STATE.

Massachusetts Medical Society.
Massachusetts Homeopathic Medical Society.
Committee on Maternal and Infant Welfare.

My dear Doctor:—

We are anxious to obtain accurate information regarding all maternal deaths that occur in Massachusetts during the present year.

For this reason, we are asking you to fill out fully the enclosed card on the death of ....., of ....., which you reported on ....., and return to us as soon as possible.

Your reply will be confidential.

Sincerely yours,
WALTER P. BOWERS, *Chairman.*

BLANK FOR REPORT ON MATERNAL DEATH.

Name Town or City

1. Date first seen?
2. Physical condition at this time?
3. Was the patient seen between the first visit and delivery?
   If so, how often?
   Yes / No } Cross out one
4. Previous history relating to No. of Pregnancy
   (a) Heart
   (b) Kidney
   (c) Lungs
   Previous labors: alive / Normal Stillborn / dead; alive / Operative Stillborn / dead
5. Confinement expected Date of delivery
6. Was the patient's urine examined before delivery?
   If so, how often?
   Yes / No } Cross out one
7. Was the blood pressure taken before delivery?
   If so, how often?
   Yes / No } Cross out one
8. Was the patient examined by vagina during labor?
   If so, how often?
   Yes / No } Cross out one
9. Was the patient examined by anyone but a physician?
10. How long was the patient in labor?
11. Was the delivery normal or operative?
    (a) If operative, nature of delivery?
    (b) If a Caesarean Section was performed, was it done before labor began?
    Yes / No } Cross out one
    If after labor began, how long was patient in labor?
12. Did the patient run a temperature after delivery or not?
    If a temperature, how high and for how long?
13. Was the delivery at home or in a hospital?
    If in a hospital, the name?
14. Was there abnormal bleeding before or after delivery?
15. Did the patient show any signs of toxemia of pregnancy?
    If so, how long before death?
16. If death followed an abortion or miscarriage, or an extra-uterine pregnancy, please give a short history of her condition and the nature of the operation done.
    (use reverse side)
17. If death followed an intercurrent disease, please state fully the nature of this disease—its onset and course, and state whether the disease or the pregnancy was the chief cause of death.
    (use reverse side)

Signed.....

ADDENDA TO THE REPORT OF THE COMMITTEE ON MATERNITY AND INFANT WELFARE.

We, the undersigned, members of the Maternity and Infant Welfare Committee, having signed the unanimous report of the Committee believe, in addition, that we should present to the Council some of the results of our investigation of the statistics concerning the practice of obstetrics since 1901 as fundamental to a proper appreciation of the problem involved.

In "The International List of the Causes of Deaths" under which all deaths are tabulated, the term "maternal death" does not occur. The so-called "maternal deaths" are classified as deaths in the puerperal state, and further the term "puerperal" is defined as follows: "The term puerperal is intended to include pregnancy, parturition, and lactation. Whenever parturition or miscarriage has occurred within one month before the death of the patient, the fact should be certified even though childbirth may not have contributed to the fatal issue."

During the past year or two, the medical profession and the public at large have heard much of the increased maternal death rates, the doubling of deaths from puerperal fever, and the appalling condition of obstetrics in Massachusetts. As representative views the printed public statement of three responsible official or semi-official bodies are presented, namely, the statements are those of the State Department of Public Health, the State Department of Vital Statistics, and our own paper, the BOSTON MEDICAL AND SURGICAL JOURNAL.

Since these statements were made there has been a change in the office of the Registrar of Vital Statistics, and the ownership of the JOURNAL has been transferred to the Massachusetts Medical Society.

The articles will be taken up in order.

Massachusetts Department of Public Health.

The Commonhealth, which is for general distribution, in Vol. 7, No. 3, page 142, states that "the maternal mortality shows an increase of 70.3% during the past sixteen years." An alarming diagram shows how deaths increased by leaps and bounds from 1901 to 1917.

The State Department of Health, in response to inquiry as to the cause of a 70% increase in maternal mortality in 16 years, as alleged by them, replied on May 16, 1921, in part as follows:

"In the first place, whatever the causes may be, there are the facts. The annual reports of the vital statistics issued by the Secretary of State, tell the story. These figures are corroborated by the figures for the whole country issued by the federal authorities. We have no reason to believe that the better reporting of deaths by physicians is the whole cause or, indeed, is a dominant factor therein. There is no doubt that physicians, nurses, school, etc., are better than they ever were before. There is probably less reliance on nature than formerly, especially in the cities: how great a factor this is, no one can say. Investigation does not bear out, apparently, the idea that much maternal mortality can be laid at the door of the midwife. Turning now to more positive statements, may I remind you that the article in *The Commonhealth*, to which reference has already been made, suggests that "the chief causes for this deplorable condition are ig-

norance (among the rich and poor) and poverty." . . . At any rate, we can fairly say this: Some unfavorable factor is entering into the practice of obstetrics and affecting it at a rate which has not been overcome by the recognized improvement in medical education and practice. . . . .May I repeat that the Department of Public Health has no indubitable proof that this, that, or the next cause is the dominant factor in the maternal mortality of Massachusetts."

The only reasons given above for a 70% increase in mortality in 16 years are (1) "ignorance," (2) "poverty," (3) "some unfavorable factor," apparently unknown.

Contrary to the opinion of the State Department of Health, we must insist that statistics are not necessarily facts. Unless they are carefully .d intelligently interpreted and explained, statistics are likly to become half truths or worse.

Massachusetts' Vital Statistics for 1917.

"In 1917, the death rate from diseases due to pregnancy and confinement had increased 34.5% (over 1901) while the death rate from typhoid fever decreased 62.3%, and the death rate from diphtheria and croup decreased 45.8% (in the same period)."

"In the light of modern knowledge of the principles of antiseptic surgery and its application to obstetric practice, it is little short of criminal that such a high death rate from diseases due to pregnancy and childbirth should continue."

When showing the increase in deaths in the Puerperal State and the decrease in deaths under Typhoid and Diphtheria, the Massachusetts Department of Vital Statistics for 1917 should have stated that the Puerperal State is a very inclusive heading, and refinements in classification increase the number of deaths in the group even if the actual number of deaths remain the same. Not so, however, with Diphtheria and Typhoid. These diseases are, today, dependent almost wholly on laboratory findings for diagnosis, whereas in 1901 various slow fevers, septic sore throat, etc., were without question, occasionally, at least, diagnosed as the above named fevers.

The Boston Medical and Surgical Journal.

This is the official or semi-official organ of the Massachusetts Medical Society. The following quotations are made from the editorial of August 5 and September 16, 1920:

"In the year 1918, in Massachusetts, 804 women died as a result of pregnancy or childbirth. The death rate in childbirth has increased steadily from 88 to 10,000 live births in 1901 to 84 in 1918. The proportion of deaths from puerperal septicaemia has more than doubled. . . . . The women of Massachusetts stand about eight times as great a chance of death in childbirth if cared for by physicians or by midwives as do the women in the poorer parts of Boston under the care of careful but inexperienced students properly supervised by experts. . . . . The condition of obstetrics in the State is intolerable. . . . . The conditions would be appalling if they had not arisen so insidiously. . . . . The JOURNAL feels that the ominous and steady increase in the maternal death rate will impel the Legislature to some definite action. . . . . Let the general practitioner explain the disproportionately large mortality to which we have referred."

When the BOSTON MEDICAL AND SURGICAL JOURNAL stated that 804 women died during 1918 as a result of pregnancy or childbirth, it should have been noted at the time that this number was about 200 above normal, due to Influenza. It would also have been fair and very much less alarming to have stated that in approximately 100,000 confinements each year, only 600 to 800 women lost their lives. Such a statement also would have been less likely to affect the birth rate unfavorably.

In stating that the women of the State at large had eight times as great chances of death as those of the Out-Patient Department of a hospital in Boston, several explanations should have been made. The Out-Patient Department accepts supposedly normal cases, and any patient becoming seriously ill in the Out-Patient Department is supposed to be removed to the hospital proper, if possible. Therefore, comparatively few deaths occur in the Out-Patient Department. Furthermore, the Out-Patient Department provides for no early pregnancies, whereas in the State at large all puerperal deaths from the very beginning of pregnancy are included at "Maternal Deaths." It is therefore very apparent that the State at large and this Out-Patient Department are in no way fairly comparable.

Attempt has been made to determine whether the official State Vital Statistics for the past twenty years give a fair interpretation of the condition of obstetric practice in this same period.

The present so-called Internatonal Classification of deaths was not adopted in this State until 1901. This classification is much more complicated than that in former use, and without question several years, at least, elapsed before it was possible to tabulate reasonably accurately. About 1910 and again in 1920 the classification was revised and there has been increasing vigor to have town and city clerks and physicians report deaths according to the standard classification. All death returns now must be accepted at the State House and at Washington, and numberless letters are sent to the city clerks for more detailed information from the physicians concerning death certificates. Not infrequently acute nephritis, convulsions, septicaemia, peritonitis, etc., are found on inquiry to be complications of the puerperal state. *Instructions to state puerperal conditions did not appear on death certificates until 1910.*

The following causes of deaths of women of childbearing age were copied from the records from one town from 1901 to 1904, none of which would be accepted today without inquiry as to whether or not they were "puerperal." These causes of death have been verified by the Secretary of State of Massachusetts:

(1) Septicaemia. Heart Exhaustion.
(2) Acute Nephritis.
(3) Septic Peritonitis. Acute Salpingitis
(4) Convulsions. Internal Hemorrhage.
(5) Acute Nephritis.
(6) Peritonitis. Septic Uterus.

A record of a still-birth a few days earlier shows conclusively that the death No. 5 of acute nephritis was really of puerperal complication. How many of the other deaths were really puerperal cannot, of course, be determined.

In examination of the death returns for 1901 of a few towns, the following causes of death among women of child-bearing age were discovered:

Convulsions.
Exhaustion.
Nephritis—Uraemic Convulsions.
Internal Hemorrhage.
Cardiac Paralysis.
Pyaemia.
Cardiac Asthenia.
Pulmonary Thrombus.
Uraemia.
Peritonitis—Pleurisy.

Any or all of these today after the customary investigation might be classified under the Puerperal State, whereas at that time they were accepted without investigation and none were tabulated as puerperal.

The distribution of deaths from puerperal fever has been studied for the years 1917, 1918, and 1919. These years were selected because statistics

were easily available, but the data are probably fairly representative. Puerperal Fever was selected rather than "all other puerperal affections," because it would seem to be a fairer index of obstetric efficiency.

In 1917, 48 cities and towns reported Puerperal Fever Deaths. Towns under 5,000 reported three such deaths.

In 1918, of the 355 cities and towns in the State only 46 reported deaths from Puerperal Fever; 309 had no such reported deaths. In the 250 towns having less than 5,000, there were but six such deaths, and in the 299 towns having less than 10,000 population, there were but 14 such deaths occurring in 12 towns.

In 1919, 48 towns reported Puerperal Fever Deaths and the towns under 5,000 reported only *one* such death.

The 250 towns having less than 5,000 population are as a rule, what might be called the rural communities. Such towns supply about one-tenth of the population; they supplied one-sixty-fifth of the deaths from puerperal septicaemia in 1917, one-thirty-second in 1918, and one one-hundredth and sixty-third of the deaths in 1919.

Various factors enter in to modify such comparisons, so that only very general conclusions, if any at all, should be drawn.

We, the undersigned, members of the Maternity and Infant Welfare Committee, believe the following information concerning the statistics of the practice of obstetrics since 1901 should be submitted:

(1) There have been many and varied improvements in the practice of obstetrics and therefore many causes for a *real* diminution in maternal mortality.

(2) No adequate cause or causes appear for poorer obstetrics and therefore no adequate causes for a doubling of maternal mortality in so short a period.

(3) There is far greater accuracy and detail in the collecting and tabulating of the official State Mortality Statistics and we believe herein lies adequate explanation for the *statistical* rather than the *actual* increase in mortality.

(4) That causes of death continue to be reported more and more accurately and in greater detail, and it will be several years, at least, before statistics become sufficiently stabilized to allow intelligent conclusions without multitudinous explanations of probable errors.

(5) The undersigned regret the readiness with which medical writers all over the country have been willing to concede inferiority of obstetrics in the United States merely because of foreign statistics gathered under unknown conditions.

(6) We believe the medical profession, in the interests of truth and its own good name, should give the public the facts in regard to this use of statistics.

We warn the profession, in closing, to take to heart this advice quoted from the Official Manual, namely, "The International List of Causes of Death" makes no pretention of being a proper nomenclature of diseases or of including a scientific classification of diseases." (Page 13 of the Introductory.)

Signed: RICHARD DUTTON.
CHAS. E. MONGAN.
ORVILLE R. CHADWELL.

October 3, 1921.

APPENDIX 7.

RESOLUTIONS OF PROTEST AGAINST LAWS RESTRICTING RIGHTS OF PHYSICIANS.

Whereas, the legislation of recent years, from the Harrison Anti-Narcotic Act to the Volstead Act, in regard to the administration and use of narcotics and stimulants has imposed upon physicians many onerous and humiliating regulations and seriously impaired the status and morale of physicians in every community, because of the distrust implied in these regulations as regards honesty and probity of medical practitioners, hitherto unquestioned and fully recognized.

And Whereas, the espionage and the distrust implied in regulations and restrictions, in addition to lowering the members of the Medical Profession in the estimation of the public and causing them to be classed as purveyors and distributors of narcotics and stimulants, have diverted the control of both into the hands of charlatans and unscrupulous persons.

And Whereas, physicians do not desire to be considered as purveyors and distributors of liquor, but rather as untrammeled advisers of their patients, who acting upon such advice, may go to an authorized Government Bureau for their supply. Such a bureau and not a physician, should be the logical successor of the saloon.

Therefore, be it *Resolved* that the Council of the Massachusetts Medical Society, in stated meeting assembled, deplores the enactment of such laws and the imposition of such humiliating and degrading and wholly unnecessary regulations upon the legitimate practice of medicine.

And be it *further Resolved*, that the Council vehemently protests against, and requests the abrogation of, such laws controlling and harassing reputable practitioners in the legitimate pursuit of their calling, and also protests against the enactment of proposed laws of the same tenor, notably the so-called "Volstead Act, Jr." or "Anti-Beer Bill," now pending in the United States Senate, which act would practically remove the right of medical men to exercise their own judgment in their own profession.

Resolved, that a copy of these resolutions and protest be spread upon the records of the Council, a copy thereof be sent to each of the Senators and Representatives in Congress from Massachusetts, and also be published in the BOSTON MEDICAL AND SURGICAL JOURNAL.

Book Review.

A French-English Dictionary for Chemists. By AUSTIN M. PATTERSON, Ph.D. 384 pp. New York: John Wiley & Sons, Inc.

A beautifully printed little book of undoubted value in a rather limited field. The reader wonders how the author knows where to draw the line in his selection of the terms which he includes. His selection is not narrow and confined to technical words, but he has given us a dictionary well adapted to the uses for which it was written.

THE DANGER OF DEFECTIVE TEETH.—It is claimed that probably 90 per cent. of the people die as a result of some infection, and ninety per cent of these infections are above the collar, and of these the majority are found in the oral cavity. From 50 to 90 per cent. of American children have defective teeth. Sound teeth mean, as a rule, good health and efficiency.

THE BOSTON
Medical and Surgical Journal
Established in 1828

THURSDAY, OCTOBER 27, 1921

Published by The Massachusetts Medical Society under the jurisdiction of the following-named committee:

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CHANNING FROTHINGHAM, M.D.
For two years HOMER GAGE, M.D., *Chairman*
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The Journal does not hold itself responsible for statements made by any contributor.

Communications should be addressed to The Boston Medical and Surgical Journal, 126 Massachusetts Ave., Boston, Mass.

"CANCER WEEK."

Not many years ago tuberculosis was the leading cause of death at all ages, even among adults. With the great success that has attended the work of the Anti-Tuberculosis Association the mortality from this disease has fallen off until now cancer is the leading cause. Cancer kills, every year, more Americans than this country lost in the whole of the recent war. Of those who reach the age of 40, one woman in every eight, one man in every fourteen dies of cancer. A large part of this mortality is, without doubt, preventable and would be prevented if both the public and the profession were as a whole fully educated to the perception of the signs and symptoms which should awaken suspicion of the disease in its incipient and curable stage.

About eight years ago at a meeting of the American Congress of Physicians and Surgeons, delegates from all the constituent societies met and approved a plan which was presented by one of its members for the control of the disease. This was the origin of the American Society for the Control of Cancer which has been since then steadily organizing and promoting a campaign of education. The campaign for this year is to include a concentrated effort to spread information simultaneously over the whole country during the week of October 30th to November 6th, which is to be known as "Cancer Week."

During this week there will be public meetings for the information of the laity both in Boston and in other cities of this Commonwealth as well as in the centres of all the other states of the Union. In Boston there will be daily clinics at which modern methods of diagnosis and treatment will be discussed and exhibited to the profession, and lectures at each of the Medical Schools. It is probable that similar clinics will be held in other cities of the State. Full programs of the exercises to be given will be published later in the JOURNAL.

The statistics and facts which reach the American Society for the Control of Cancer show that there are still too many physicians who are not sufficiently impressed with the urgent need of prompt action in suspicious cases and with the disastrous effects of delay in diagnosis. The JOURNAL would urge every member of the profession whose line of work has not put him into direct contact with modern advance in the management of this disease to make a point of attending at least one of these clinics.

THE CONSTITUTIONALITY OF THE MEDICAL PRACTICE ACT.

IT seems to afford entertainment for attorneys representing convicted, unregistered practitioners to raise the question of the constitutionality or meaning of the law which requires all persons who attempt to relieve human ills in this Commonwealth to first secure registration. Now comes one Henry J. Dragon, who has been active in various parts of the State claiming to be skilled in treating the results of fractures, and contends that the law only applies to treatment by medicine and that a bone-setter is immune. Intellects which can only interpret the practice of medicine as the administration of drugs may be excused for raising this contention, for it is quite reasonable to assume that a mind of this calibre may have only a dim conception of the definition of the words, "practice of medicine." But in the light of the several state supreme court decisions relating to this subject, decisions which have been sustained by the United States Courts, one may wonder at the good faith of an attorney who leads a client to spend the necessary amount of money involved in proceedings before the higher courts.

As a nation we are regarded as gamblers, and it may be that this trail leads to the disposition to take a chance, hoping that some new sidelight of individual practice may be used to bring out some defect in the law, or it may be that the spirit of controversy which

sometimes seems to result from court proceedings leads one to pursue a forlorn hope with the chance of developing some unsuspected weakness. So far as the law is concerned, the last decision removes one other source of contention; at least it will deter high minded and well read lawyers from encouraging an ignorant pretender in his desire to prolong litigation. Mr. Dragon had better try to earn his living in some other way, for the fees obtained in his attempted medical practice will hardly supply the sinews of war for other defenses.

LIFE EXPECTANCY.

IT is generally understood that there has been an increase in longevity in this generation, due largely to public health activities and the various educational campaigns which have been promoted by organizations devoted to the study of special diseases.

As was noted in the JOURNAL of October 20th, the death rate from tuberculosis has fallen below that of cancer and the effect of several other diseases on the mortality rate shows changing relative importance. We speak of typhoid as the vanishing disease in comparison with the high mortality rate of a generation ago. This is no doubt due both to better understanding of the factors entering into its spread by carriers and the employment of anti-typhoid vaccine. This is an illustration of the application of scientific knowledge. Diphtheria, on the other hand, is waiting for more general application of effective preventive measures before another step can be recorded in the reduction of mortality from this disease. The great advances made are to be credited to preventive medicine, for although curative medicine has progressed, it is in the aggregate secondary in the final accounting. One great preventive agency has been built up by an insurance company dealing with more than thirteen million men, women and children. This company carries on an active health campaign by the dissemination of information, and a certain amount of nursing service. In the large group under the operation of a wise policy since 1910, the death rate has been reduced more than one-fifth. In 1920 there were 38,000 fewer deaths than if the 1911 mortality rate had prevailed. Looking at the problem in another way, the expectation of life has been increased among white males dating from the age of ten years, from 45.6 to 49.5 years. This is the largest recorded increase in longevity in any similar period in public health records. The white females did not show a corresponding gain, and other reports of this company show that the incidence of septicaemia among the child-bearing women has slightly increased. No analysis is at hand to show whether pregnancy and childbirth actually prevented the women from showing a gain equal to that of men, but the question is an important one and should be studied. White females showed a net gain of only 1.4.

This gain in both classes, although small when taken in individual cases, when applied to thirteen million shows stupendous additions to the productive power of a nation. An interesting racial comparison brought out by the Second Industrial Congress on Eugenics shows that among the foreign-born races the Russians have the highest expectation of life and the least favorable expectation is among the Irish born, for the Russian can expect if he is alive and well at ten years of age to live to be fifty-three years old, whereas the Irish child can only expect to attain to thirty-nine years. The women of both races, however, show up somewhat better than the men. Italians rank next to the Russians, and Germans only slightly better than the Irish.

These facts show that public health work may find a great opportunity for good among some of our foreign-born citizens.

MEDICAL NOTES.

THE four western district societies, Berkshire, Franklin, Hampshire and Hampden, held a joint meeting at the Hotel Kimball, Springfield, Mass., on Friday, October 7, 1921. Primarily for the purpose of studying impending legislation that directly and indirectly interests the profession, the meeting proved to be of even greater value; for the one hundred and fifty men present welcomed the opportunity to renew acquaintanceship and exchange ideas. After an informal luncheon, real progress was immediately made in the election of a permanent chairman for future similar meetings, Dr. G. L. Gabler of Holyoke, and a permanent secretary, Dr. A. P. Merrill of Pittsfield. With the four western counties thus organized it is intended, as voiced in the call to this meeting "to make our influence felt in shaping the legislation relative to health matters rather than later to endeavor to amend or annul such acts as are inimical to our interests."

Dr. John Bartol, President of the State Society, made an earnest plea that the four thousand doctors of Massachusetts unite to influence healthful legislation, not by lobbying, but in a clean way. He expressed the hope that by grouping the district societies and holding frequently such meetings as this, much would be accomplished through coöperative effort.

Dr. J. S. Stone, for years our faithful guardian at the State House, spoke of the stern necessity for watchfulness. Each year sees this effort made to pass legislation against vaccination and vivisection, for example; and each year sees the effort made by the introduc-

tion of seemingly innocent bills that disclose their insidiousness only on close and careful scrutiny. Besides such routine work the Society's representatives at the State House are constantly consulted by legislative committees on a great diversity of subjects that pertain to the health of the community.

The Hon. B. Loring Young, speaker of the House of Representatives, in an interesting and logical way explained the problems of taxation as shown by state expenditure, and showed that of the nearly forty million dollars appropriated for the state this year, sixteen million, or 40%, were for the care of those who are a burden on those who are able to maintain themselves. Many of the questions relating to taxation are medical in some degree and legislators are seeking for technical advice in order to deal logically with them. This meagre reference can only call attention to a speech which was a strong presentation of matters which medical men should be interested in. The speech as a whole appears on page 487 of this JOURNAL and should be carefully studied. Mr. Young has always shown deep concern in all matters of interest to the profession and has cordially conferred with our legislative committee. His advice has always been constructive.

Dr. Channing Frothingham, in an interesting and amusing talk, gave a résumé of his investigations in the fields of osteopathy and chiropractic. The theories on which these cults rest he showed to be most plausible and when put into practice, productive of some good, which laymen are quick to recognize. The paramount weakness of these cults, however, a weakness which their followers admit and are attempting to overcome, lies in the impossibility of proving the theories by scientific facts and experiments. Just so long as that weakness persists, which is probably forever, osteopathy and chiropractic cannot be recognized and accepted by scientists. Inasmuch, however, as they constitute therapeutic agencies of some value along certain lines which is really the case, it is unwise to ignore or prosecute their followers, but rather to find them a place in the medical world where their efforts can be properly directed and controlled.

MEETING FOR GROUP III OF THE DISTRICT SOCIETIES.—The group meeting for the Middlesex South, Norfolk and Norfolk South Districts will be held November 29 instead of the date previously given.

DAVID H. GIBSON, M.D., Tufts Medical School, 1921, has been elected the national president of the Federation of College Catholic Clubs, which has jurisdiction over the Catholic Clubs in the non-Catholic colleges of the United States. Dr. Gibson served last year as president of the Louis Pasteur Club, Tufts Medical and Dental Schools.

CANCER WEEK CAMPAIGN NOTES.—Some time ago, at Dr. Powers' request, Dr. W. W. Keen, of Philadelphia, prepared a popular article on the subject of Cancer for the *Woman's Home Companion*. This article is in every way excellent and admirably suited as a ten-minute paper which might be read before any organization or group during the Cancer Week. The material is taken largely from Dr. Keen's extensive experience with cancer and is most lucid and readable. After seeing the manuscript, Dr. Powers was impressed with the desirability of giving this article as wide a circulation as possible, and conceived the idea of having it read in the churches on Sunday, October 30. It is strongly urged that an attempt be made to do this and also to interest Fraternal Orders which may hold meetings in your communities during the latter part of October or any time in November, to arrange for it to be read before its membership. In order that as many church congregations as possible may be reached in this way it is suggested that a personal interview be had with ministers and priests by some member of your local committees throughout the country. The Bishop of each Diocese should be seen for he can often make the necessary arrangements with the individual churches under his jurisdiction. It is appreciated that some clergymen will prefer to use the article as the basis for a sermon or a brief announcement, but it is hoped that each may be provided with a reprint of this paper to be used as may seem suitable.

It would appear that many Fraternal Orders will be interested and willing to coöperate. Dr. Powers has succeeded in having the subject presented before the Board of Directors of the Knights of Columbus in the hope that they will authorize the reading of this paper in all their lodges in this country and Canada during the Cancer Week.

The Society has ordered 100,000 reprints of this article in order that a sufficient supply may be available for this purpose. Orders may be placed either through this office or with your State Chairman. As they will be mailed out direct from the publishers of the *Woman's Home Companion* in Springfield, Ohio, it would perhaps be best for small orders to come through the State Chairmen, though if time will not permit or if for any reason you desire to send your requests direct to the National Office, we shall send them to you postpaid in any desired number.

THE WORCESTER DISTRICT MEDICAL SOCIETY.—About eighty members attended the joint meeting of the Worcester District Medical Society and the Worcester North District Medical Society held in the Assembly Room of the Clark University, Worcester, Wednesday evening, October 12, 1921.

Dr. John W. Bartol, President of the Massachusetts Medical Society, addressed the meeting and urged the members to combine to urge beneficial legislation. He did not mean that the Society should conduct a lobby at the State House, but he did mean that the legislators were entitled to a free and perfectly proper statement from the medical profession of the rights and wrongs of impending legislation. He said that often legislators acted in ignorance in important legislation when so-called experts testified on opposite sides of the same question.

Dr. W. P. Bowers in discussing the President's address, said that he was grateful that so many had come to this joint meeting and hoped that others would follow and that it would be the beginning of a unity of action which would protect the interests of the people in health legislation.

Dr. George L. Tobey, Jr., of Boston, read a paper on Acute and Chronic Inflammations of the Middle Ear. He said that numerous societies had been organized to combat many of the diseases of the system such as tuberculosis, cancer, diseases of the eye, etc., but none for the conservation of hearing. He said that the prevalence of so much chronic ear disease and presence of so many adults with defective hearing, warranted every effort to prevent and correct chronic ear diseases of childhood. He said that all ear diseases are secondary to infections of the nose and throat, and always traceable to tonsils and adenoids. He emphasized the fact that it was not always large tonsils and adenoids that caused trouble, but that many adenoids that were the cause of trouble were not large enough to cause mouth breathing. He advocated that all general practitioners should be qualified to recognize a bulging ear drum and equipped to do a paracentesis. He startled his audience by stating that he had been removing tonsils and adenoids in the acute condition with splendid results. He first did this at the solicitation of Dr. E. H. Place of the South Department of Boston City Hospital in the acute conditions of scarlet fever, and since then in other diseases, with good results. He stated that chronic catarrhal deafness of adults was due to infections of childhood and that frequently adults had adenoids. He advocated conservative middle ear surgery which would cure many cases of chronic diseases, and finally mastoid operations for those cases where the conservative surgery did not yield results.

Dr. Edward H. Trowbridge read a paper on "The Duty of the Physician to Himself, His Confrères and to the Public at Large." He mentioned the fact that the present day medical student had an elaborate curriculum but that the subject of ethics was not taken up during the whole course. He said that every physician should give respectful consideration to the opinion of others and that much of the lack of harmony in the profession at present was due to unfair criticism. The place to thrash out differences of opinion among the profession is at medical meetings such as these. He advocated a code of ethics for every doctor's office and the enrollment of doctors' names with their specialties in every directory. He appealed for the coöperation of all members of the profession in health legislation.

Dr. G. W. Ellison of Spencer, in discussing the paper spoke of the change of the evening meetings, and urged more discussion of the papers as read. He complimented Dr. Trowbridge's paper and said that the physician was a noteworthy poor business man.

After discussion, Dr. J. B. Fowler of Spencer, was made chairman of a committee of nine to secure the opinion of the members of the Society at large on any subject as they arise, this opinion to be transferred to similar committees of other societies as needed.

A committee was appointed to arrange for further joint meetings of the Worcester District and the Worcester North District Medical Societies. The next meeting of the Worcester District Society will be held in Spencer, November 9-19, 1921.

JOSEPH PRENN, M.D., of 536 Commonwealth Avenue, Boston, Massachusetts, has opened an office at 28 Pleasant street, Worcester, Mass.

DURING the week ending October 15, 1921, the number of deaths reported was 183 against 184 last year, with a rate of 12.60. There were 22 deaths under one year of age against 37 last year.

The number of cases of principal reportable diseases were: Diphtheria, 31; scarlet fever, 20; measles, 11; whooping cough, 4; typhoid fever, 5; tuberculosis, 24.

Included in the above were the following cases of non-residents: Diphtheria, 3; scarlet fever, 1; tuberculosis, 3.

Total deaths from these diseases were: Diphtheria, 1; typhoid fever, 1; tuberculosis, 8.

Included in the above was the following case of non-resident: Diphtheria, 1.

BOSTON'S EXPENSES.—Boston leads all the large cities of the United States in per capita expenditure, with a figure of $35.06. For health the city spends 83 cents, and for schools $9.11. Only one city, Pittsburgh, spends more for

health with the figures of 97 cents, and for schools Los Angeles exceeds Boston by $1.77. Baltimore is the most economically managed large city in this country.

REGISTRATION OF NURSES.—There were 365 nurses examined by the State Board of Registration of Nurses October 13 and 14. Each nurse was asked to state her preference for future work. The result was as follows:

For public health work, 45; for institutional, 131; industrial, 12; private duty, 167, and 20 undecided.

Most of these nurses are recent graduates, and this tabulation is a fair indication of the attitude of nurses toward the special fields of work. This does not mean that all the nurses who would prefer institutional work, for example, will find positions, so that more than the 167 private duty nurses will take up this work than is indicated by the figures. Usually 15 to 20 per cent. fail to secure registration, hence these figures are only suggestive for the rejected applicants may modify the number of available nurses for any one of these divisions.

BIRTHS AND INFANT DEATHS IN MASSACHUSETTS.—There were 91,692 births in the State in 1920, a gain of 3,983 over 1919. The death rate among infants under one year of age increased three per 1000 births, the total deaths being 8,337.

Excluding figures relating to the colored race, Massachusetts, with a death rate of 91 per 1000 births, is exceeded only by Maine with a rate of 102, Vermont with 96, and Michigan and Connecticut, each with 92.

These figures apply only to the registration area.

THE THIRTY-FIRST ANNUAL SESSION of the New York and New England Association of Railway Surgeons will be held at Hotel McAlpin, New York City, October 29, 1921. A most attractive program has been arranged at which some of the most eminent men in the profession will read papers and participate in discussions.

Miscellany.

RÉSUMÉ OF COMMUNICABLE DISEASES SEPTEMBER, 1921.

General Prevalence.

Of communicable diseases 3,311 were reported during September as compared with 3,318 for August; this is the least number for any month this year.

Anterior Poliomyelitis.—Fifty-four cases of poliomyelitis were reported during September as compared with 61 for August. Just as last month, this disease has seemed to center itself about certain foci; thus from three foci, one in the eastern, one in the northeastern and one in the western part of the state, 47 of the 54 cases were reported.

Diphtheria shows a slightly increased incidence over last month, there being 526 cases reported for September as compared with 516 for last month.

Dog-bite requiring anti-rabic treatment—15 cases were reported for the month.

Gonorrhea and Syphilis.—Gonorrhea showed a slight decrease while syphilis was reported in about the usual numbers: totals, 508 and 196, respectively.

Measles.—201 cases were reported for this month as compared with 268 for August; this is the smallest monthly total since September, 1920.

Lobar Pneumonia was reported in 126 instances; the total for last month was 76.

Scarlet Fever.—279 cases were reported for this month as compared with 232 for August.

Pulmonary Tuberculosis.—593 cases were reported for September, a slight increase over the number reported for August.

Typhoid Fever.—129 cases were reported during the month, while for the same period of 1920 there were 198 cases.

Whooping Cough.—248 cases were reported as against 375 for the previous month; this is the smallest monthly total in several years.

RARE DISEASES.

Anterior Poliomyelitis was reported from Adams, 1; Barnstable, 1; Boston, 10; Cambridge, 2; Everett, 2; Haverhill, 6; Holbrook, 1; Holyoke, 1; Lawrence, 6; Lowell, 1; Ludlow, 1; Lynn, 1; Manchester, 2; Mansfield, 1; Merrimac, 1; Methuen, 1; New Bedford, 1; Newburyport, 1; Northampton, 1; North Attleboro, 1; Norwood, 2; Quincy, 2; Revere, 2; South Hadley, 1; Swampscott, 3; Westfield, 2. Total, 54.

Anthrax was reported from Deerfield, 1.

Dog-bite requiring anti-rabic treatment was reported from Boston, 1; Dighton, 1; Everett, 1; Fall River, 2; Hingham, 1; Holyoke, 1; Lowell, 7; Taunton, 1. Total, 15.

Dysentery was reported from Boston, 1; Framingham, 1; Haverhill, 1; Malden, 1. Total, 4.

Encephalitis Lethargica was reported from Beverly, 1; Boston, 2; Cambridge, 1; Chelsea, 1; Haverhill, 2; Lowell, 1; Quincy, 1; Swampscott, 1; Wakefield, 1; Worcester, 1. Total, 12.

Epidemic Cerebrospinal Meningitis was reported from Boston, 3; Cambridge, 2; Greenfield, 1; Newburyport, 1; Walpole, 1. Total, 8.

Malaria was reported from Boston, 3; Chelsea, 2; Dedham, 3; Douglas, 1; Dover, 1. Total, 10.

Pellagra was reported from Boston, 1; Danvers, 1. Total, 2.

Septic Sore Throat was reported from Cambridge, 1; Fall River, 1; Lowell, 1; Newton, 1; Peabody, 1; Somerville, 1. Total, 6.

Tetanus was reported from Boston, 4; Brockton, 1; Cambridge, 1; Leominster, 1; Winchester, 1. Total, 8.

Trachoma was reported from Boston, 2; Cambridge, 1; Everett, 1; Fall River, 1; Haverhill, 1; Needham, 1; Somerville, 1; Worcester, 1. Total, 9.

Trichinosis was reported from Maynard, 1.

"CANCER WEEK."

Mr. Editor:—

As a part of the activities of "Cancer Week" the following clinics and demonstrations in the hospitals of Greater Boston have been arranged. To any or all of these exercises the members of the medical profession are cordially invited. In addition to these clinical demonstrations for physicians, a number of lectures, open to the public, and special demonstrations and talks to nurses, social service workers, public health officers, fraternal orders and women's clubs, have been provided.

In other cities of Massachusetts the local committees of this Society and the district officers of the Massachusetts Medical Society are coöperating to provide similar opportunities to inform the public in regard to this disease.

Very truly yours,

EDWARD REYNOLDS, *Chairman,*
MRS. R. C. STURGIS, *Secretary,*
Massachusetts Committee of the American Society for the Control of Cancer.

MONDAY, OCTOBER 31.

St. Elizabeth's Hospital.

10.30 A.M.

A series of ten-minute papers by members of the Staff.

Rectal Carcinoma. Dr. Joseph Stanton.
The Relation of Trauma to Malignancy. Dr. Francis Jantzen.
The Etiology of Cancer. Dr. Henry Rowen.
Early Diagnosis of Uterine Cancer. Dr. John Sullivan.
Carcinoma of the Colon. Dr. George Keenan.
The Early Diagnosis of Intestinal Malignancy. Dr. John J. Whoriskey.
Cancer of the Cervix Uteri. Dr. Charles Kickham.
Malignant Disease of the Bones. Dr. Thomas Broderick.
Presentation of Cases of Malignancy of the Genito-Urinary Tract. Dr. Arthur Chute.
The Pathology of Malignant Neoplasms. Dr. Francis McCarthy.

MONDAY, OCTOBER 31.

The Boston Dispensary.

11 A.M. to 1 P.M.

Cancer as an Out-patient Problem.

1. Medical Department. Dr. W. E. Preble.
2. Dermatological Department (Cancer of the Skin and its Treatment by Radium). Dr. H. J. Perry.
3. Surgical Department. Dr. H. F. Day.
4. X-ray Department (Demonstration of Radiographs as an Aid to Diagnosis). Dr. H. A. Osgood.
5. Laboratory Department (Demonstration of Specimens and Slides). Dr. W. A. Hinton.

MONDAY, OCTOBER 31.

The House of the Good Samaritan.
(Binney Street, Brookline)

4 P.M. to 5 P.M.

A General Clinic on Cancer. (Will be given in the Cancer Ward.) Dr. R. H. Miller.

TUESDAY, NOVEMBER 1.

The Peter Bent Brigham Hospital
Amphitheatre-Operating Building.

10 A.M. to 12 M.

The Pathology of Malignant Disease in Relation to its Curability. Dr. Wolbach.
Malignant Disease of the Central Nervous System. Dr. Cushing.
Malignant Disease of the Genito-Urinary Tract. Dr. Quinby.
The Operability of Cancer in a General Surgical Clinic. Drs. Cheever and Homans.
The Place of X-ray Therapy in the Treatment of Malignant Disease. Dr. Reynolds.
Operative clinic during the morning.

TUESDAY, NOVEMBER 1.

Collis P. Huntington Memorial Hospital.

3.15 P.M. to 5 P.M.

The Cancer Commission of Harvard University. Dr. R. B. Greenough.
Radium in the Treatment of Disease. Dr. William Duane.
Cancer of the Skin. Dr. L. S. McKittrick.
The State Free Diagnosis Service. Dr. J. H. Wright.
Cancer of the Buccal Cavity. Dr. C. C. Simmons.
Cancer of the Uterus. Dr. G. A. Leland, Jr.
Laboratory Work in Bio-physics. Dr. W. T. Bovie.
Radium in the Treatment of Leukæmia. Dr. G. R. Minot.
Radium in the Treatment of Cancer of the Genito-urinary Organs. Dr. G. G. Smith.
The Treatment of Cancer of the Nose, Throat and Accessory Sinuses. Dr. D. C. Greene.

WEDNESDAY, NOVEMBER 2.

Massachusetts Homeopathic Hospital—Amphitheatre.

10 A.M. to 12 M.

Massachusetts Homeopathic Medical Society.
(Fifteen-minute talks on the early diagnosis of cancer.)

Cancer of the Uterus. Dr. M. C. Green.
Cancer of the Rectum. Dr. W. K. S. Thomas.
Cancer of the Lip. Dr. H. J. Lee.
Cancer of the Breast. Dr. C. Crane.
Cancer of the Bladder. Dr. R. C. Wiggin.
Cancer of the Stomach. Dr. T. E. Chandler.
The Treatment of Cancer by Radium. Dr. W. T. Lee.
The Use of High Voltage X-rays in the Treatment of Cancer. Dr. H. F. Friedman.
The Control of Cancer. Dr. C. T. Howard.

THURSDAY, NOVEMBER 3.

Carney Hospital.

10 A.M. to 12 M.

A Clinic on Cancer.

Dr. John T. Bottomley will speak on the subject of cancer. The Surgical Service will demonstrate the results of operative treatment of early cases, and the Roentgenological Service will show the results of x-ray treatment. An operative clinic on cancer cases will be given.

THURSDAY, NOVEMBER 3.

The Free Hospital for Women.

3 P.M.

Cancer of the Cervix. Dr. W. P. Graves.
Cancer of the Ovary and Breast. Dr. F. B. Pemberton.
Cancer of the Body of the Uterus. Dr. J. V. Meigs.

FRIDAY, NOVEMBER 4.
Massachusetts General Hospital—Surgical Amphitheater.
10.00 A.M.

The Control of Cancer. Dr. R. B. Greenough.
Cancer of the skin. Dr. C. J. White.
Cancer of the Lip and Mouth. Dr. C. C. Simmons.
Cancer of the Nose and Throat. Dr. D. C. Greene.
Cancer of the Stomach. Dr. C. A. Porter.
Cancer of the Colon and Rectum. Dr. D. F. Jones.
Cancer of the Breast. Dr. R. B. Greenough.
Cancer of the Uterus. Dr. Lincoln Davis.
Cancer of the Genito-Urinary Organs. Dr J. D. Barney.
Bone Sarcoma. Dr. T. W. Harmer.
The X-ray Therapy of Cancer. Dr. G. W. Holmes.

FRIDAY, NOVEMBER 4.
Collis P. Huntington Memorial Hospital.
3.15 P.M. to 5.00 P.M.

The Cancer Commission of Harvard University. Dr. R. B. Greenough.
Radium in the Treatment of Disease. Dr. William Duane.
Cancer of the Skin. Dr. L. S. McKittrick.
The State Free Diagnosis Service. Dr. J. H. Wright.
Cancer of the Buccal Cavity. Dr. C. C. Simmons.
Cancer of the Uterus. Dr. G. A. Leland, Jr.
Laboratory Work in Bio-Physics. Dr. W. T. Bovie.
Radium in the Treatment of Leukaemia. Dr. G. R. Minot.
Radium in the Treatment of Cancer of the Genito-Urinary Organs. Dr. G. G. Smith.
The Treatment of Cancer of the Nose, Throat and Accessory Sinuses. Dr. D. C. Greene.

SATURDAY, NOVEMBER 5.
The Boston City Hospital.
Cheever Amphitheater.
10.30 A.M. to 12 M.

The Present Conception of Cancer. Dr. R. N. Nye.
The Recognition of Lung Metastases. Dr. S. W. Ellsworth.
The Roentgen Diagnosis of Early Cancer of the Stomach. Dr. P. F. Butler.
The Clinical Diagnosis of Early Cancer of the Stomach. Dr. F. W. White.
The Diagnosis of Early Skin Cancer. Dr. T. W. Thorndike.
The Use of X-ray and Radium in the Treatment of Malignant Disease. Dr. H. Osgood.
The Treatment of Cancer of the Stomach. Dr. F. B. Lund.
Pre-malignant and Early Malignant Conditions of the Breast. Dr. E. H. Nichols.
The Early Recognition of Malignancy in the Cervix. Dr. E. B. Young.

(Corrected Program.)

BOSTON TUBERCUOSIS ASSOCIATION.
INSTITUTE FOR PHYSICIANS.

Morning, Wednesday, October 26, 1921, Dr. Floyd presiding.

10-11—Subject, Tuberculosis in the Community; speaker, Dr. James Alexander Miller, President, National Tuberculosis Association, New York City.

11-11.15—Subject, Regional Anatomy of the Lungs; speaker, Dr. Alexander S. Begg, Professor of Anatomy, Boston University, School of Medicine.

11.15-11.35—Subject, Pathology of Tuberculosis, with specimens; speaker, Dr. Lawrence W. Smith, Department of Pathology, Harvard Medical School, Boston, Mass.

11.35-12.05—Subject, Relation of Boards of Health to the General Practitioner in the Handling of Tuberculosis; speaker, Dr. William C. Woodward, City Health Commissioner, Boston, Mass.

12.05-12.35—Subject, Aid which the State Offers in Controlling Tuberculosis Through St.te Sanatoria and Consultation Clinics; speaker, Dr. Eugene R. Kelley, State Health Commissioner, Boston, Mass.

Afternoon, Wednesday, Dr. Hawes presiding.

2-3—Subject. What May Be Expected from Sanatorium Treatment; speaker, Dr. Vincent Y. Bowditch, Director Sharon Sanatorium, Sharon, Mass., and ex-President, Massachusetts Tuberculosis League.

3-4—Subject, Common Pulmonary Diseases Confused with Tuberculosis; speaker, Dr. Edward O. Otis, Professor, Tufts College Medical School, Boston, Mass., and President, Massachusetts Tuberculosis League.

Morning, Thursday, October 27, 1921, Dr. Floyd presiding.

10-11—Subject, Early Diagnosis of Tuberculosis; speaker, Dr. Lawrason Brown, Saranac Lake, N. Y., Trudeau Sanatorium.

11-11.30 — Subject Artificial Pneumothorax and Postural Rest in the Treatment of Tuberculosis; speaker, Dr. Cleaveland Floyd, Director of the Outpatient Clinic, Boston Consumptives' Hospital.

11.30-12.30—Subject, Clinical Physical Signs of Tuberculosis; speaker, Dr. Richard Cabot, Professor of Medicine, Harvard University.

Afternoon, Thursday, Dr. Hawes presiding.

2-3—Subject, Laboratory Aids in the Diagnosis of Tuberculosis; speaker, Dr. Frederick T. Lord, Visiting Physician, Massachusetts General Hospital, Boston, Mass.

3-4—Subject, Correlation of Clinical Findings and X-ray in Cases of Tuberculosis; speakers, Dr. John B. Hawes, Director of Clinic on Pulmonary Diseases, Massachusetts General Hospital, and President, Boston Tuberculosis Association; Dr. Geo. W. Holmes, Roentgenologist, Massachusetts General Hospital, Boston, Mass.

SOCIETY NOTICE.

ESSEX NORTH DISTRICT MEDICAL SOCIETY.—The quarterly meeting of the Society will be held at Essex Sanatorium (Tuberculosis), Middleton, Mass. (Tel. Danvers 300-W), upon invitation of County Commissioners and Superintendent, O. S. Pettingill, M.D., Wednesday, November 2, 1921, at 2 P.M., sharp, and will be a joint meeting with these District Societies: Middlesex North, Middlesex East and Essex South.

These speakers will be present:

J. W. Bartol, M.D., of Boston, President of the Massachusetts Medical Society.

C. F. Painter, M.D., of Boston, Chairman Standing Committee on Medical Education and Medical Diplomas.

J. S. Stone, M.D., of Boston, Secretary Standing Committee on State and National Legislation.

W. P. Bowers, M.D., of Clinton, Editor of the BOSTON MEDICAL AND SURGICAL JOURNAL.

C. Frothingham, M.D., of Boston, Chairman of a Council Committee to investigate the "cults."

At 4 P.M. clinical material will be demonstrated, and six reels of moving pictures on diagnosis, etc., of tuberculosis will be shown, and the Sanatorium will be inspected.

At 5.30 sharp, dinner will be served.

The next meeting of the Censors will be held at Hotel Bartlett (Tel. 1260), Haverhill, Thursday, November 3, at 2 P.M., sharp.

J. FORREST BURNHAM, M.D., *Secretary*,
567 Haverhill St., Lawrence, Mass.

F. W. SNOW, M.D., *President*.
Oct. 25, 1921.

ESSEX SOUTH DISTRICT MEDICAL SOCIETY.—The Censors of the Essex South District Medical Society will meet at the Salem Hospital, Thursday, November 3, 1921, at 3.30 P.M. Prospective candidates should communicate with the Secretary at once.

GEORGE E. TUCKER, *Secretary*,
Salem.

Correspondence.

THE FUNCTION OF MEDICAL MEETINGS.

Spencer, Mass., October 10, 1921.

Mr. Editor:—

At a recent meeting of "The Brookfield Medical Club" we came down for a moment from the heights of scientific endeavor to talk over some of the homely problems that concern the average general practitioner, and by that designation I mean all physicians, whether in rural communities or not, who are not members of some hospital staff, and came to these conclusions:

First. That medical meetings in general, and this applies to district societies, etc., are partial failures because little, if any time is devoted to the free discussion of medical problems as applied to the individual and his needs as a unit of the brotherhood of physicians. Papers are read and a rush for the door is made, the men not knowing a thing more about the puzzles that are clogging the brain of their neighbors than before they came. The attendance of medical meetings is not purely a perfunctory duty to be gotten out of so easily, and withal unsatisfactorily, but that a good part of *each* meeting should be set aside and *used* for discussing personal and local problems.

Second. That the tendency to centralization of power is to be viewed with growing concern by every member of the profession. Local problems should have a local remedy and the application made by local men. That the tendency of present-day legislation is toward such a centralization of power is not to be denied, but such efforts should be strenuously resisted, even at the expense of delay in the enactment of progressive law, for the most good ultimately will come from the conscientious and intelligent action of men in the medical fraternity who, being wise, anticipate the action of the legislators and make action by them unnecessary. On the other hand, however much the passing of laws seems to correct present evils, too much of it will be to hedge in and cramp the medical man in his work. That this decentralization might be effected a system of close communication between the units in the state should be established. We should have a greater interest in the *history* of our profession, yet the movements of many civic organizations, and efforts of lay individuals will be written in large letters across the pages of our history, and blind many minds to the records of our really unparalleled achievement. But do not all of us see the encroachment of civic organizations in our own field and the scarcely veiled *commands* to do certain things?

The fathers of law were entirely willing for the medical profession to direct and control medical affairs in the great crisis of the World War, because they realized it was their business and no one else could direct it successfully, but now they have to look out for their votes, and stand ready to incline an ear to any appeal, and it is to negative the force of such appeals and show a greater array of opposing strength that the profession direct its efforts toward the control of such law-makers. They are not to be blamed for they are elected to try to express the will of the majority, therefore we *must* represent the majority opinion, and *anticipating* all *necessary* reforms and legislation and resisting the unnecessary, put into effect a program which will render legislation and reform through civic agitation entirely uncalled for.

This can only be done by the unified action of *all* the men of the state, whether members of the Massachusetts Medical Society or not; an analysis, *at the ground*, of conditions and opinions as they exist among the community groups, and the appointment of a small committee in each society or group whose duty it shall be to keep informed of the opinions of the members of that community and keep closely in touch with such other committees as are formed throughout the state. This would insure a rapid interchange of ideas and a quick mobilization of the force of medical opinion throughout Massachusetts. The result of the concentration and exchange of this crystallized opinion will be beneficial and far reaching. In that way, the elected officials of our Society could more fully serve us because they would hold a hand on our pulse all the time. An analysis of conditions and opinions furnished to the editor of the JOURNAL from time to time would be desirable.

Such an organization, a decentralized collection of groups, will require some work, the unceasing efforts of a definite ferment in each community, and, in time, possibly the employment of a society agency to link up the chain, but bearing in mind the necessity of maintaining the active integrity of each small group. In the beginning, however, action can be carried on by correspondence and personal touch in a simple way.

I am instructed by the Brookfield Medical Club to get in touch with each medical organization in the state and invite them to form such a committee, stir up discussion among its members, and let the result be known to us. We agree to transmit to the committee of each other organization the resulting conclusions or whatever information we may have at any time. Inquiries and personal opinions will be welcomed.

This is not a movement for revolution. We have too much of good to dispense with any of it, but we do need an additional element of good healthy growth. Progress is the watchword, change if necessary, but at a pace more rapid than that of the general public.

Very sincerely,

J. R. FOWLER, M.D.

P. S. Since writing the above, the Worcester District Medical Society was approached with the above proposition, and it was voted that the President appoint a committee of seven, which was done.

J. R. F.

CENSORS' MEETING.

The Censors of the Middlesex South District Medical Society will meet for the examination of candidates at the Colonial Club, 20 Quincy Street, Cambridge, Thursday, November 3, 1921, at 2 o'clock.

Candidates should make application to the Secretary at least one week before the examination.

FREDERIC B. M. CADY, *Secretary.*
10 Chauncy Street, Cambridge.

NOTICE.

HARVARD RESEARCH CLUB.—The meeting of the Research Club to be held at the Harvard Medical School Amphitheatre in Building A, at 12.30 o'clock on Friday, October 28, will be addressed by Professor Lawrence J. Henderson on "Blood as a Physical Chemical System."

All physicians are invited.

Very truly yours,

COMMITTEE.

NOTICE.

CHILDREN'S HOSPITAL—Clinical Meetings of the Staff of the Boston Children's Hospital will be held in the amphitheatre once a month from November to May inclusive. The meetings will be held on Friday afternoons at 4.30 P.M. All members of the profession are cordially invited to be present. The dates of the meetings are November 4th, December 9th, January 13th, February 10th, March 10th, April 14th, and May 12th.